TWO WEEKS UNTIL ENROLLMENT: QUESTIONS FOR CCIIO

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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TWO WEEKS UNTIL ENROLLMENT: QUESTIONS FOR CCIIO

THURSDAY, SEPTEMBER 19, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:19 a.m., in room 2123 of the Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, Burgess, Gingrey, Scalise, Harper, Olson, Gardner, Griffith, Johnson, Long, Ellmers, Shimkus, DeGette, Butterfield, Castor, Welch, Tonko, Green, Yarmuth, Dingell, and Waxman (ex officio).

Staff present: Sean Bonyun, Communications Director; Karen Christian, Chief Counsel, Oversight; Noelle Clemente, Press Secretary; Julie Goon, Health Policy Advisor; Brad Grantz, Policy Coordinator, Oversight & Investigations; Sydne Harwick, Legislative Clerk; Brittany Havens, Legislative Clerk; Sean Hayes, Counsel, Oversight & Investigations; Andrew Powaleny, Deputy Press Secretary; John Stone, Counsel, Oversight; Tom Wilbur, Digital Media Advisor; Phil Barnett, Democratic Staff Director; Brian Cohen, Democratic Subcommittee Staff Director, Senior Policy Advisor; Hannah Green, Democratic Staff Assistant; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Nelson, Democratic Deputy Staff Director; Stephen Salsbury, Democratic Special Assistant; and Matthew Siegler, Democratic Counsel.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good morning. I convene this hearing of the Subcommittee on Oversight and Investigations. Well, in less than 2 weeks enrollment in qualified health plans under the Patient Protection Affordable Care Act will begin. It is the law of the land. Today we hope to discuss the many challenges and issues that may arise over the coming weeks. Most of the concerns about the law currently can be reduced to one question: Is the Administration ready?

Since passage of the President's Healthcare Law, the Administration has consistently told us that the government will be ready when open enrollment begins on October 1 and the exchanges start on January 1. Yet our experience has shown that rosy predictions

about the future of the Healthcare Law often given way to the results of this rushed and rocky implementation.

The law has many problems and so much so that half of it was simply done away with for a year. While individuals must comply with the law's requirements starting on January 1 or pay a penalty, this is not so for businesses and companies who are able to delay the employer mandate for a year.

Despite the Administration's promises about lower premiums, evidence continues to mount that some individuals will face extreme rate hikes when the exchanges open, as much as double the price they are currently paying. And the Administration's promise that if you like your coverage you can keep it rings especially hollow now with news reports almost every day about businesses moving the spouses and families of their employees or their retirees into the exchanges. If the President's promises were true, we wouldn't hear stories about major airlines losing millions of dollars to the Healthcare Law, and we wouldn't hear about the spouses of thousands of employees losing their coverages.

Meanwhile, any sort of oversight over the Healthcare Law remains taboo for the law's defenders. Last month this committee sent letters to many of the recipients of federal funding to participate in the Navigator Program under the law. We asked some fairly basic questions. How many people are you hiring? What are you paying them? Are you performing background checks? We should expect that groups receiving federal dollars to enroll people in exchanges should have answers to those questions as enrollment begins in less than 2 weeks.

In the course of this investigation the committee has had many productive calls with recipients of Navigator funding. I have had some personal meetings myself which have been very fruitful. In fact, many of the organizations were prepared to answer our questions we believe will be ready to properly perform their Navigator duties. Yet, we have also seen that the Navigator Program, like many of the programs created under the Healthcare Law, has been impacted by the Administration's delay in implementing the law.

According to a GAO report issued in June, the Administration issued the Navigator grants 2 months behind schedule. The Administration had planned to issue the first round of awards in June but did not end up issuing them until August. The Administration had originally planned to begin Navigator training in July, but HHS did not finalize the training programs until August 29. This delay naturally reduced by almost half the time available to Navigators to begin training and preparing for enrollment.

So today we will ask Mr. Gary Cohen, the Director of the Center for Consumer Information and Insurance Oversight, to explain how the abbreviated training schedule for Navigators will affect the program. We will also ask Mr. Cohen to address some of the concerns we have identified in our review of the grant applications.

We learned that some Navigators are planning on going door to door to conduct enrollment activities. A report issued yesterday by the Oversight and Government Reform Committee indicates that CCIIO representatives are aware of problems linked to door-to-door outreach activities such as scammers knocking on doors and falsely

representing that they are Navigators, and yet this activity is still permitted under the Navigator Program.

We have also learned that the return on taxpayer dollars varies wildly among Navigator grant recipients. The Administration is paying one Navigator $80,000 to enroll 312 people. That is $80,000 of taxpayer funding to enroll not even a person a day.

On the other hand, other groups clearly have incredibly high expectations. Another applicant estimated that they would enroll approximately 75 percent of the individuals directly contacted, resulting in hundreds of thousands of enrolled individuals. There is a wide difference in expectations and workload.

Our concerns over the safety of consumer data and health information remain as well. One Navigator plans to survey and track those who attend community meetings and another promises additional pay if a Navigator enrolls a certain amount of individuals. I have concerns about paying for that.

Meanwhile, one Navigator told committee staff that they believe background checks are important, yet these are not a required action. Our responsibility in conducting oversight of Federal programs is to identify waste, fraud, and abuse, and the best case, asking questions about Federal spending and shining a light on programs can identify problems before taxpayer dollars are wasted and allow those problems to be corrected. A wait-and-see approach to oversight of the Healthcare Reform Law does not seem appropriate when its implementation has been regularly botched by delays and uncertainty.

Let me add to this. As a clinician and psychologist myself, it was hardly ever appropriate for me or my colleagues in the medical field to wait until problems were at a severe or critical level. We like to know problems early and take action. That is the appropriate thing to do, and any claims that we are doing otherwise are inappropriate and spurious at best.

So I welcome Mr. Cohen, and I look forward to asking questions about what we can expect in the coming weeks.

[The prepared statement of Mr. Murphy follows:]

OPENING STATEMENT OF THE HON. TIM MURPHY

In less than two weeks enrollment in qualified health plans under the Patient Protection and Affordable Care Act will begin. Today we hope to discuss the many challenges and issues that may arise over the coming weeks. Most of the concerns about the law currently can be reduced to one question: "Is the administration ready?"

Since passage of the president's health care law, the administration has consistently told us that the government will be ready when open enrollment begins on October 1 and the exchanges start on January 1. Yet, our experience has shown that rosy predictions about the future of the health care law often give way to the results of the administration's rushed and rocky implementation.

The law is so problematic that half of it was simply done away with for a year. While individuals must comply with the law's requirements starting on January 1or a pay a penalty, this is not so for businesses and companies who were able to delay the employer mandate for a year. Despite the administration's promises about lower premiums, evidence continues to mount that some individuals will face extreme rate hikes when the exchanges open—as much as double the price they are currently paying. Finally, the administration's promise that "if you like your coverage you can keep it" rings especially hollow now, with news reports almost every day about businesses moving the spouses and families of their employees, or their retirees, onto the exchanges. If the president's promises were true, we wouldn't hear stories about

major airlines losing million of dollars to the health care law, and we wouldn't hear about the spouses of thousands of employees losing their coverage.

Meanwhile, any sort of oversight over the health care law remains taboo for the law's defenders. Last month, this Committee sent letters to many of the recipients of federal funding to participate in the Navigator program under the law. We asked some fairly basic questions: how many people are you hiring? What are you paying them? Are you performing background checks? We should expect that groups receiving federal dollars to enroll people in exchanges should have answers to these questions, as enrollment begins in less than two weeks. In the course of this investigation, this Committee has had many productive calls with recipients of Navigator funding-in fact, many of the organizations were prepared to answer our questions and we believe will be able to properly perform their Navigator duties.

Yet, we have also seen that the Navigator program, like many of the programs created by the president's health care law, has been impacted by the administration's delay in implementing the law. According to a GAO report issued in June, the administration issued the Navigator grants two months behind schedule. The administration had planned to issue the first round of awards in June—they didn't end up issuing them until August. The administration had originally planned to begin Navigator training in July—but HHS did not finalize the training program until August 29. This delay naturally reduced by almost half the time available to Navigators to begin training and preparing for enrollment.

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Our concerns over the safety of consumer data and health information remain as well. One Navigator plans to "survey and track...those who attend community meetings" and another promises additional pay if a Navigator enrolls a certain amount of individuals. Meanwhile, one Navigator told Committee staff that they believe background checks are important, yet these are not a required action.

Our responsibility in conducting oversight of federal programs is to identify waste, fraud, and abuse. In the best case, asking questions about federal spending and shining a light on programs can identify problems before taxpayer dollars are wasted—and allow those problems to be corrected. A "wait and see" approach to oversight of the health care reform law does not seem appropriate when its implementation has been regularly botched by delays and uncertainty.

I welcome Mr. Cohen and I look forward to asking him questions about what we can expect in the coming weeks.

# # #

Mr. MURPHY. I now recognize Ranking Member DeGette for her opening statement, but she is going to yield to Mr. Waxman because he has another commitment this morning.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman. Thank you, Representative DeGette, for yielding to me this time to make an opening statement.

Oversight is important and valuable, but the Affordable Care Act oversight of the last 3 years has not been to enlighten the committee or improve the law. It appears to be part of the efforts by the Republican party to engage in partisan attacks on this law and if they could do it, even sabotage the Affordable Care Act.

I released a report last month highlighting the unprecedented Republican campaign to undermine the law. Forty-one repeal votes, refusals to expand Medicaid to cover millions of low-income Americans, and the imminent threat to shut down the entire Federal Government or force a catastrophic government default if the law is not repealed. There is no legitimate purpose served by the letters to 51 Navigators who are community groups, food banks, community health providers, and many similar non-political organizations tasked with trying to help inform the public about the Affordable Care Act benefits. This request was ill-timed and a serious mistake, and I find it amazing to hear the Chairman talk about how they haven't had enough time to do their job but now we are trying to, by the committee, divert them from doing their job by answering all sorts of questions.

The letters sent to them were without a predicate or evidence of wrongdoing. They serve only to burden and intimidate these organizations just as they are beginning their critical work. My staff yesterday released an analysis of the Navigator Program. Our investigation found that Navigators will help millions obtain health insurance coverage, that they have extensive experience assisting individuals with federal and state benefit programs, and they have effective privacy protections in place.

In short, the Republican rhetorical attacks on the Navigator Program I believe are unjustified and inconsistent with the facts. It is hard to escape the conclusion that it was designed to intimate these groups and discourage participation in the program. Thanks to the Affordable Care Act millions of Americans will be able to get high-quality, affordable insurance. The worst abuses of the insurance companies have been ended. This Republican approach, I believe, is bad for the country.

I want to now yield the balance of my time to the gentleman from North Carolina, Mr. Butterfield.

Mr. BUTTERFIELD. Thank you, Mr. Waxman, for yielding time, and thank you for your extraordinary leadership. You not only wrote the Affordable Care Act, but you got it through this committee. Thank you very much.

Mr. Chairman, I am pleased to announce that tens of thousands of my constituents in North Carolina have already benefited from the Affordable Care Act. One-hundred and thirty thousand seniors are now eligible for Medicare preventative services, 41,000 children can no longer be denied coverage based on pre-existing conditions, 8,200 young adults now have coverage on their parents' plans. It has been a long path, and we are almost there with the beginning of open season on October 1, less than 2 weeks away, we will be one step closer to helping many Americans receive affordable and quality healthcare. The opening of the marketplace, the education and support provided by, yes, the Navigators and the outreach by HHS will help directly enroll 1.1 million uninsured people and as-

sist an additional 7.3 million uninsured people to receive health insurance.

But instead of touting the success of soon having nearly every American insured, my Republican friends have forced more than 40 votes to dismantle and defund the Act. The chairman of this committee in my opinion abused his investigatory authority by launching a fishing expedition of Navigators who received funding solely for the purpose of discrediting the program. This, Mr. Chairman, distracts the Navigators' attention. You know it, and I know it, from their mission of helping families to access health insurance.

Someone said that many of these Navigators will be going door to door. I hope they will be going door to door to enroll every uninsured American. A North Carolina newspaper recently reported that one of my North Carolina Republican colleagues who serves on this committee said that she would be pleased if the Congressional Navigator inquires stymies the non-profit is Navigator work, and she is quoted in that article as saying, "If this ended up resulting in a delay, I wouldn't be unhappy about it."

This is an outrage, Mr. Chairman. I would hope that October 1 that we would unite and make sure that every American gets access to affordable healthcare. The American people deserve it, and we need to bring this debate to a close.

Thank you, Mr. Waxman. I will yield back to you, sir.

Mr. MURPHY. The gentleman yields back. I now recognize for 5 minutes the gentleman from Texas, Dr. Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Well, thank you, Mr. Chairman. I appreciate the recognition, and here we are a dozen days from the start date of October 1 where the open enrollment is going to occur. I don't know a whole lot more than I did the last time Mr. Cohen was here at the end of April of this year. Since that time I have been told time and time again by officials from Health and Human Services, Center for Medicare, Medicaid Services, Treasury, the White House, and of course, even you when you were here, Mr. Cohen, that the exchanges would definitely be ready to go live on October 1, 2013.

In addition, the federal hub that is supposedly going to be operational in a couple of days we have not had made available to us any of the testing data that reportedly has been done, and that obviously is an important aspect that many of us continue to have a great deal of interest.

Even more concerning is the fact that federal officials have assigned much of the responsibility for the education and outreach to federally-funded Navigators.

Now, similar to the Administration's other delays, while Health and Human Services had initially planned to issue the first round of Navigator grants in June and begin training in July, the grants were issued on August 15, and a training program was not available to the Navigators until the end of that month. You got $67 million, $13 million more than originally budgeted, $67 million of taxpayer money taken by threat by the IRS from taxpayers across this country, $67 million has been given out to Navigators across the Nation, and we don't know the purpose of that money.

Now, I am going to reference an article from August 4 of 2012, so this is over a year ago it appeared in the "New York Times." The article says, "Federal officials are looking for private contractors to provide in-person assistance to consumers and to operate call centers. A contractor will also help the government decide who gets federal subsidies, expected to average $6,000 a person, and who is exempt from the tax penalties that will be imposed on people who go without insurance."

Again, this is August 4 of 2012, so it is not like the agency didn't know this was coming. The article goes on to say, "Mr. Hash, the Director of the Federal Office of Health Reform, said that federal exchanges will operate essentially in the same manner as the state-based exchanges, however, they differ in a significant way. States have done their work in public, but planning for the federal exchanges has been done almost entirely behind closed doors."

I think that is one of the problems that many of us on this committee have with that.

"Sabrina Corlette," continuing in the article, "Sabrina Corlette, a Research Professor at Health Policy Institute of Georgetown University, said the federal exchanges were much more opaque than the state exchanges." You have to wonder what value is there in opacity in that situation from an Administration who said it valued transparency.

Yesterday morning people who received their copy of the "Wall Street Journal," were greeted with the headline, "Burden Shifts on Insurance. Firms Change Health Coverage, Walgreen to Give Workers Payments to Buy Plans." You know, when the healthcare law was sold by the President across this country, it was sold with the admonition if you like what you have, you can keep it. If you like your doctor, you can keep your doctor. If you like your health plan, you can keep your health plan but apparently not if you work for Walgreen's.

You know, we get criticized on this side of the dais because of attempts to reign in the Affordable Care Act. No apology for the number of times that legislation has come to the floor of the House to try to pull this thing back. It has never been popular, it has never enjoyed popular support, it is becoming increasingly clear how dangerous this law is to people's health and healthcare, how dangerous it is to our economy.

But seven times the President has signed one of those bills into law. So gone are the 1099 provisions, gone are the Class Act, gone are several other things. But here is a point that people miss. Seven other times the President has decided himself that parts of the law were unimportant, and the law that he signed was not, in fact, going to endure. What about the Pre-Existing Condition Program? This law was sold on the backs of people with pre-existing conditions across this country, and yet when someone showed up on February 1 of this year to enroll in the PECP Program, they were told, sorry, sister, the program is closed. So for 11 months people with pre-existing conditions who had been promised relief are just simply wondering the country wondering what they are supposed to do.

The shop exchanges were supposed to open January 1, 2014. You put it off to 2015. Removing the reporting requirements and relying

on self-attestation, delaying final contracts with contractors, delaying the employer mandate, removing out-of-pocket caps, no premium information. This was promised to me by the Administrator of CMS——

Mr. MURPHY. The gentleman's time——

Mr. BURGESS [continuing]. In July in this committee, that I would have this information by September 15. Mr. Cohen, we are going the long way now to September 15 and if you go——

Mr. MURPHY. The gentleman's time——

Mr. BURGESS [continuing]. To the Web site today on healthcare.gov, it says come back and see us in a few weeks. We are busy trying to get it ready.

Thank you, Mr. Chairman, for your indulgence. I will yield back my time.

Mr. MURPHY. Thank you. Now go to Ms. DeGette for 5 minutes.

Ms. DEGETTE. Thank you very much, Mr. Chairman. Before I make my opening statement I would like to recognize the newest member of the Energy and Commerce Committee, Congressman John Yarmuth from Kentucky. We are very glad to have him.

[Applause.]

Ms. DEGETTE. And I would ask unanimous consent to allow him to participate in the hearing today. He doesn't have subcommittee assignments yet, but we know he is going to be on this fabulous subcommittee very soon.

Mr. MURPHY. Without objection.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much.

Mr. Chairman, we have spent more than our share of time in this subcommittee on the Affordable Care Act talking about implementation. It is our seventh hearing this year, and we really haven't seen any problems come up in all the hearings. So I want to thank Mr. Cohen for coming back again during a very busy time in his schedule as the exchanges open on October 1.

On this subcommittee it is our job to unearth the facts in an objective and non-partisan manner. So with 2 weeks to go before the marketplaces go live, I want to talk for a moment about what we have seen this year.

We have obtained documents and conducted extensive investigation of health insurance premiums under the ACA, and what did we find out? The ACA is going to allow millions of Americans to obtain affordable insurance for the first time ever. HHS this week released a new report showing that nearly six in ten currently uninsured Americans, 23.2 million people, would be eligible to get insurance coverage for under $100 a month. A Kaiser Family Foundation study released earlier this month concluded that premiums are generally lower than expected. A new RAM study reached similar conclusions.

The facts also show that individuals with health insurance coverage are already benefiting from the Act. The HHS revealed that 6.8 million customers saved an estimated $1.2 billion on their premiums in 2012, due to the rate review provisions in the ACA.

This committee also conducted an investigation into the contractors responsible for implementing the ACA's marketplaces. This was one of my favorite hearings because what did the facts show? They showed that the contractors will be ready on October 1, that they are taking appropriate steps to protect consumer privacy, and as an added benefit, they are creating thousands of jobs.

Last month, Mr. Chairman, you opened an investigation into the ACA Navigator Program. That is what we are here today for. You sent dozens of letters to dozens of civic and community groups that received grants to help their neighbors sign up for ACA benefits. In a letter to Chairman Upton, Ranking Member Waxman expressed his concern that this investigation was designed not to enlighten the committee but to intimidate the Navigators, and I am sorry to say I kind of agree with those criticisms.

There seems to be little reason to put these burdens on the Navigators just as they were starting to get their work going with the public, and the Committee's investigation shows there is no basis for the allegations about the Navigators.

Yesterday the minority staff released a supplemental memo summarizing its review of the Navigator documents. Mr. Chairman, I would like to ask that that be made part of the record.

Mr. MURPHY. Without objection.

[The information follows:]

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

September 18, 2013

To: Committee on Energy and Commerce Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Preliminary Findings of Affordable Care Act Navigators Investigation

On August 29, 2013, Chairman Upton and 14 Republican members of the House Committee on Energy and Commerce sent a detailed request for documents and briefings to 51 groups that received grants to serve as Navigators to help the uninsured sign up for benefits under the Affordable Care Act.

The following day, Ranking Member Henry A. Waxman wrote: "there is no legitimate predicate for these letters and no evidence of any malfeasance from any of the organizations. It is an abuse of your oversight authority to launch groundless investigations into civic organizations that are trying to make health reform a success."

The Committee has received grant applications and other information from 42 of the 51 organizations. A review of these applications reveals that there is no basis for the Republican concerns about the Navigator program. It finds that:

- **Navigators will help millions obtain health insurance coverage.** The recipients of the Navigator grant aim to directly enroll over one million uninsured people in the Health Insurance Marketplaces and Medicaid and will reach an additional 7.3 million people through public education efforts.

- **Navigators have extensive experience assisting individuals with federal and state benefit programs.** The role of educating and enrolling individuals for benefits is not a new role for these organizations; most have vast experience helping individuals in targeted communities with Medicaid or other health insurance coverage, food security programs, legal services, and other counseling or assistance programs.

- **Most Navigators are nonprofit, community service providers, and all Navigators are nonpartisan organizations.**

- **Navigator grant recipients have effective privacy protections in place.** All the grant recipients must abide by statutory provisions providing for the privacy and security of personally identifiable information under the Affordable Care Act, and many are taking additional steps to protect individuals' privacy or already have extensive experience handling highly sensitive personal financial and health data information

I. BACKGROUND

On August 29, 2013, Chairman Upton and 14 Republican members of the House Committee on Energy and Commerce sent request letters to 51 groups that received grants to serve as Navigators to help the uninsured sign up for benefits under the Affordable Care Act. The letter demanded that the groups provide "all documents and communications related to your Navigator grant," and asked that they provide briefings and answer many questions on organization budgets and employee training, education, monitoring, review, and supervision.[1]

The following day, Ranking Member Henry A. Waxman wrote: "there is no legitimate predicate for these letters and no evidence of any malfeasance from any of the organizations. It is an abuse of your oversight authority to launch groundless investigations into civic organizations that are trying to make health reform a success."[2] He concluded that the impact of the Republican investigations "is not to enlighten the Committee, but to intimidate and divert resources from the effort to implement the law."[3]

Recent comments by Republican Committee member Rep. Renee Ellmers, who signed the Committee's original letter, appear to confirm Ranking Member Waxman's concern. The *Charlotte News and Observer* reported that "she said she would be pleased if the congressional navigator inquiry stymies the nonprofits planning navigator work. 'If this ended up resulting in a delay, I wouldn't be unhappy about it,' Ellmers said."[4]

One organization that received the letter from the Committee has withdrawn from the program and returned the funding, telling the Committee that it is returning the grant because "emerging State and Federal regulatory scrutiny surrounding the Navigator program requires us to allocate resources which we cannot spare and will distract us from fulfilling our obligations to

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[1] *See, e.g.,* Letter from Chairman Fred Upton et al. to Arizona Association of Community Health Centers (Aug. 29, 2013).

[2] Letter from Ranking Member Henry A. Waxman to Chairman Fred Upton (Aug. 30, 2013).

[3] *Id.*

[4] *NC Groups Working to Implement Health Care Law Targeted by GOP Data Request,* Charlotte News and Observer (Sept. 7, 2013) (online at www.newsobserver.com/2013/09/07/3166895/nc-groups-working-to-implement.html#storylink=cpy).

our clients."[5] The grant to this organization, Cardon Outreach, was to fund outreach activities in Pennsylvania, Ohio, Florida, and Utah.[6]

On September 9, 2013, the Department of Health and Human Services (HHS) responded to the Committee's request. In an effort to "enable the Navigators to focus on training staff to begin to assist uninsured Americans," the Department answered the Committee's questions and provided copies of the Navigator grant applications. The Department produced 42 grant applications from the 51 organizations originally requested by the majority. At the request of Ranking Members Waxman and DeGette, Democratic staff reviewed the Navigator grant applications produced by the Department. This memo provides a summary of the preliminary findings of this review.

II. FINDINGS

A. Navigators Will Help Millions of Americans Obtain Health Care Coverage

According to their application materials, the recipients of the 42 Navigator grants reviewed by the Committee will directly enroll nearly 1.1 million uninsured people in the Health Insurance Marketplaces and Medicaid. They also expect to assist an additional 7.3 million people through public education efforts – such as marketing campaigns, community enrollment and education events, and extensive information, outreach, and referral services – about the benefits of the Affordable Care Act.

In Texas, Navigators will help over 450,000 people sign up for health insurance coverage and will educate over 1.2 million; in Florida, Navigators will help over 330,000 people sign up for health insurance coverage and will educate more than 830,000.

Many of these groups will focus on ensuring that minorities, low–income individuals, individuals with mental illnesses or substance abuse problems, and other vulnerable populations have access to health care coverage under the law. One organization explains that its "primary target clientele are Hispanic field workers and their families."[7] Their programs "reach a variety of ethnicities and communities, but most clients have limited education, many limited English language skills, and are culturally Hispanic."[8] Another organization will target specialized navigation services to "people in recovery from mental illness and/or substance abuse, individuals in active addiction, or those who are seeking behavioral health treatment services."[9]

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[5] Letter from Charles W. Kable, Cardon Outreach, to Members of the Committee on Energy and Commerce (Sept. 13, 2013).

[6] *Citing scrutiny, firm won't aid Pa. on ACA,* Associated Press (Sept. 17, 2013).

[7] [Redacted], *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges,* at 33 (June 6, 2013).

[8] *Id.*

[9] [Redacted], *[Redacted] has been developed [to] provide specialized navigation services to people in recovery from mental illness and/or substance abuse, individuals in active addition, or seeking treatment,* at 26 (June 7, 2013).

A third organization explains that it traditionally "serves persons who are considered poor or working poor and who are in need of insurance. Some of these populations are single mothers with children, individuals who are victims of crime and domestic violence and urban populations."[10]

B. Navigators Have Extensive Experience Assisting Individuals with Federal and State Benefits

Outreach to these vulnerable communities is not a new role for these organizations. One Navigator grant recipient explains its extensive experience, writing, "[s]ince 2008, our Benefits Access Program has linked families in need with public and private benefits for which they are eligible, especially food stamps, free tax preparation, utilities assistance programs, Medicaid, ... and most recently, disaster assistance in the aftermath of Superstorm Sandy."[11]

Another group states that over the last 12 years, it "has helped more than 80,000 individuals and families enroll in and retain public health insurance including Medicaid, Child Health Plus, and Family Health Plus."[12] Another recipient highlights the work of just one of its nonprofit consortium members, explaining that it has "extensive prior experience assisting low-income individuals with public health insurance, such as Medicaid and CHIP, including applying the regulations to an individual's situation, administrative and judicial appeals, and navigating the bureaucratic process inherent in the administration of public benefit programs."[13]

At least one organization plans to complete the same education and outreach activities for the Affordable Care Act that is undertook during the rollout of the Medicare Part D program. The organization explained in its Navigator grant application that in the past, it served as the lead "in an effort to enroll eligible, low-income populations in the Low Income Subsidy (LIS) and the Medicare Part D benefit."[14] The organization explained:

> Beginning in 2004, this effort encompassed education and outreach efforts for initial efforts into these brand-new federal programs. [The organization] mobilized its network to hold regional enrollment events, conducted telethons, provided mobile enrollment services, fielded telephone inquiries through its hotline, performed eligibility screening, and completed hundreds of applications for the LIS and during open enrollment periods

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[10] [Redacted], *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges*, at 12 (June 5, 2013).

[11] [Redacted], *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges*, at 12 (June 6, 2013).

[12] [Redacted], *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges*, at 43 (June 6, 2013)

[13] [Redacted], *Statewide consortium of navigators to enroll the uninsured into the federally facilitated marketplace*, at 23 (June 6, 2013).

[14] [Redacted], *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges*, at 34 (June 5, 2013).

for Medicare Part D. This experience demonstrates a long-standing commitment to expanding access to health coverage through public education and outreach.[15]

C. Most Navigators Are Nonprofit Community Service Providers

The grant applications reviewed by the Committee staff reveal that the vast majority of Navigators are nonprofit community service providers, many of whom have extensive experience in assisting low-income people with complex public benefit programs. Forty of the 42 organizations for which the Committee has applications are not-for-profit entities. Thirty-five are nonprofits or nonprofit-led consortia, two are state universities, two are private entities or private entity-led consortia, one is a county government, and one is a municipal corporation.

Republican leaders have raised concerns that the Navigators would use information provided from individuals they help sign up for coverage for "fundraising, voter registration efforts, [or] campaign activities."[16] But all 42 of the organizations whose applications were reviewed by the Committee staff were nonpartisan and nonpolitical in nature.

D. Navigators Have Effective Privacy Protections in Place

Republican attorneys general have written that "we are concerned that [HHS] has failed to adequately protect the privacy of those who will use the assistance programs connected with the new health insurance exchanges."[17] But the Democratic staff review of Navigator grant applications indicates that the recipients have effective privacy protections in place.

All the grant recipients must abide by 45 C.F.R. § 155.260, the statutory provisions providing for the privacy and security of personally identifiable information under the Affordable Care Act. These regulations dictate the manner in which grant recipients can collect, use, and access personally identifiable information. Among other requirements, the law provides that "[p]ersonally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure."[18] Any organization or individual that knowingly or willfully uses or discloses information in violation of these regulations is subject to a civil penalty of $25,000 per individual, per disclosure.[19]

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[15] *Id.*

[16] *See, e.g.,* Letter from Chairman Fred Upton et al. to Arizona Association of Community Health Centers (Aug. 29, 2013).

[17] Letter from State Attorneys General to the Honorable Kathleen Sebelius (Aug. 14, 2013).

[18] 45 C.F.R. § 155.260(a)(3)(vii)

[19] Exchange Establishment Standards And Other Related Standards Under The Affordable Care Act, 45 C.F.R. § 155.260.

In addition to these privacy safeguards, many organizations that received navigator grants are taking additional steps to protect individuals' privacy. At least 15 of the organizations have additional privacy practices for their Navigator staff, including background checks, training in Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, and computer security policies.

Moreover, many of the organizations already have extensive experience handling highly sensitive personal financial and health data information in the course of their work to assist individuals in need of state or federal assistance program. Grant applications reveal that at least 27of the 42 organizations have extensive past experience in handling such information. One organization explained:

> As a HUD-approved housing counseling agency, [the organization] already has extensive data privacy and security standards and protocols in place as a result of our contracts to provide foreclosure prevention counseling. During the mortgage modification application process, clients are required to gather and bring in a variety of official documents that include private and/or confidential information; applications are submitted online, but the paper copies must be kept on file at our location. Application data is submitted online, protocols regarding the use of computers and laptops or tablets are already in accordance with 45 C.F.R. § 155.260. In addition to online data privacy and security policies, we have protocols in place that physically separate client data files in a secured room away from other program areas and offices. We have written procedures for accessing filed client data for appointment and returning it to the client file, (including signature logs identifying the staff who access files) and policies governing the data destruction once the mandatory storage timeframe has expired. Finally, all staff and contractors are required to sign confidentiality agreements covering client information as a condition of employment. These policies and protocols will be used for the Navigator program as well.[20]

[20] [Redacted], *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges*, at 37 (June 7, 2013).

Ms. DEGETTE. The investigation found that Navigators would help millions of people obtain health insurance coverage. They have extensive experience assisting individuals with federal and state benefit programs. Most Navigators are non-profit, non-partisan community service providers, and they have effective privacy provisions in place. Those are the facts, and they show good news.

Mr. Chairman, you talked in your opening statement about these false Navigators that are going door to door, and that is a concern. That is why we have to have the real Navigators in place so they can sign people up, and just yesterday HHS, DOJ, and the FTC announced a massive anti-fraud effort. I would suggest we all work together to stop any kind of fraud in the system and with that, Mr. Chairman, I want to yield the balance of my time to Representative Castor.

Ms. CASTOR. Well, I thank the Ranking Member for yielding time.

I wanted to relay today the enthusiasm I am hearing back home from so many of my neighbors, particularly when it comes to now the bar against discrimination for our neighbors who have pre-existing conditions. Just over the past few weeks I have met with leaders and communities with multiple sclerosis, diabetes, HIV Aids, cancer that now see hope. They have hope because they will be able to get insurance for a change and not be discriminated against.

Now, since September of 2010 children with these chronic diseases and chronic conditions have been able to get insurance in the greater Tampa Bay area. That has meant 237,000 children have been able to get insurance where before they couldn't. Now, beginning January 1 this will apply to adults. So they are particularly enthused, but at the same time they are very troubled by the Republican obstruction and sabotage. They don't understand why now people are going to block access to the doctor's office and affordable care.

So I look forward to discussing that today.

Mr. MURPHY. Thank you. The gentlelady's time has expired.

By the way, I also want to recommend the Chairman of Environment and the Economy here, Mr. Shimkus, is going to sit on this hearing. Thank you for being here.

I will now swear in the witness.

I will introduce him. Mr. Cohen is the Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight, recently served as General Counsel for California Health Benefits Exchange, and we will swear in the witness.

[Witness sworn.]

Mr. MURPHY. You are now under oath and subject to the penalties set forth in Title XVIII, Section 1001 of the United States Code. You may now please give a 5-minute summary of your written testimony.

TESTIMONY OF GARY COHEN, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. COHEN. Good morning, Chairman Murphy, Ranking Member DeGette, and members of the subcommittee. I look forward to answering your questions regarding CMS's ongoing work to implement the Affordable Care Act, including the Navigator Program.

As we approach the beginning of open enrollment, CMS and all of our partners across the country are focused on helping people sign up for affordable healthcare coverage that begins on January 1. We are already seeing competition works. The creation of new marketplaces is encouraging insurers to offer plans at competitive rates.

As a result, in 16 states preliminary rates are 19 percent less expensive than the CBO projected. States are using their improved rate review powers to help keep rates affordable and, according to recent estimates as Congresswoman DeGette mentioned, many consumers may be able to pay $100 or less per person per month for coverage in 2014.

When open enrollment begins on October 1, it is one more step toward putting in place one of the core promises of the Affordable Care Act: affordable, accessible health coverage that begins next year. We are working hard to ensure that consumers have the information they need about their coverage options. Healthcare.gov has received more than 3 million unique visits since its re-launch this summer, and as required by the law, CMS has awarded grants to over 100 organizations to serve as Navigators.

These grantees are groups and organizations with a proven ability to reach out to likely marketplace consumers in their local communities. Navigators include the Pennsylvania Association of Community Health Centers, which since 1981 has been supporting community health centers across the state in their mission of providing access to quality primary healthcare. There are organizations like Ascension Healthcare, which is the Nation's largest Catholic and non-profit health system; the Martin Luther King Health Center, which has been serving the people in Shreveport, Louisiana, since 1986; the University of Mississippi Medical Center; the United Way of Metropolitan Tarrant County, which will be collaborating with 17 other organizations in assisting Texas residents and which has been helping people in the Fort Worth and Arlington areas for 90 years; and the University of Georgia, which was founded in 1785, as the Nation's first state-chartered university.

I find the suggestion that these organizations, that the United Way or the University of Georgia or any of the rest are going to prey on people by stealing their identities to be utterly without foundation. Helping people is the reason that these organizations exist.

Navigators are prepared to provide accurate and impartial assistance to consumers shopping for health insurance coverage. They will be required to adhere to strict privacy and security standards including how to safeguard a consumer's personal information. Navigators will be required, the individuals will be required to

complete approximately 20 hours of initial training to be certified, will take additional training throughout the year, and will renew their certification yearly.

The work they will be doing is similar to work that has been done for years by SHPS to help Medicare beneficiaries understand their options. I find it really unfortunate that many of these organizations are facing distracting scrutiny while they prepare to begin this important work.

One organization, a group prepared to serve individuals in four states, withdrew from the program as a result of this scrutiny. This type of scrutiny risks creating an insinuation that these well-respected organizations and institutions like food banks, large state universities, and United Way chapters have somehow done something inappropriate before they have spoken to a single consumer. These groups are trying to do the same type of work they have done in their communities for years and in some cases decades, and it is unfortunate that they are the subject of inquiries that suggest they are doing something wrong by helping people in their communities enroll in healthcare coverage. They are feeling obligated to spend time responding to inquiries and insinuations that they are hiring unqualified staff or won't follow federal grant regulations instead of beginning the task of helping people in their communities. It is disappointing that their resources and attention have been diverted at this critical time.

I have been asked countless times over the last year whether we will be ready for day one, and it often brings to my mind the implementation of Medicare Part D. Now, I wasn't at CMS during Medicare Part D implementation, but I read the news stories like everyone else, and I understand that there were some serious challenges; seniors not enrolled correctly in plans, beneficiaries turned away from pharmacies without their medications. But CMS solved these problems, and the Part D Program is now strong and successful.

And if you ask beneficiaries about Part D today you won't hear, oh, that is the program that had so many problems when it launched. Instead you will hear, that is the program that helps me afford my medication.

And I believe that will be the story of the Affordable Care Act. The people actually benefiting from the law won't be talking about what happened on October 1 or on January 1. They will talk about how their child can get health coverage even though he has a preexisting condition. They will talk about how they no longer have to pay more for premiums just because they are women. They will talk about how they finally decided they could retire because they can now afford coverage they buy on their own. They will talk about the security of not having to face bankruptcy due to a diagnosis.

We may encounter some bumps when open enrollment begins, but we will solve them because it is what we do. We are here to help people get health insurance, and we at CMS take this responsibility very seriously.

Thank you, and I am happy to answer your questions.

[The prepared statement of Mr. Cohen follows:]

STATEMENT OF

GARY COHEN, J.D.

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

AFFORDABLE CARE ACT IMPLEMENTATION

BEFORE THE

U. S. HOUSE COMMITTEE ON ENERGY & COMMERCE
SUBCOMMITEE ON OVERSIGHT AND INVESTIGATIONS

SEPTEMBER 19, 2013

Testimony of Gary Cohen on Affordable Care Act Implementation
House Committee on Energy & Commerce, Subcommittee on Oversight and Investigation
September 19, 2013

Good morning, Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee. Thank you for the opportunity to update you on some of the recent work at the Centers for Medicare & Medicaid Services (CMS) to implement the Affordable Care Act to put in place strong consumer protections, provide new coverage options, and give Americans the additional tools to make informed choices about their health insurance. Millions of Americans have already benefited from this law, and in less than two weeks, the Health Insurance Marketplace will be open for business, giving consumers an easy way to compare and enroll in more affordable health insurance coverage. To prepare for the start of open enrollment, CMS has worked hard to build, refine and test the infrastructure that will allow Americans to enroll in coverage confidently, simply, and securely. We are working with a variety of partners and organizations to help people learn more about the Affordable Care Act and their coverage options.

Reforming the Insurance System

Even before the Health Insurance Marketplace opens for business, millions of consumers have already benefited from the Affordable Care Act. For example, insurance companies are now required to justify a rate increase of 10 percent or more, shedding light on arbitrary or unnecessary costs. Since this rule was implemented,[1] the number of requests for insurance premium increases of 10 percent or more have plummeted from 75 percent in 2010[2] to 43 percent in 2011 to 26 percent in 2012 and an estimated 14 percent in the first quarter of 2013[3], and Americans have saved an estimated $1.2 billion on their health insurance premiums, thanks to review of all rate increase requests.[4] These figures strongly suggest the effectiveness of rate review.

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[1] Health Insurance Rate Review – Final Rule on Rate Increase Disclosure and Review: http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf
[2] http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review09112012a.html
[3] http://aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.cfm
[4] http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.cfm

The rate review program works in conjunction with the 80/20 rule (or the Medical Loss Ratio rule),[5] which generally requires insurance companies in the individual and small group markets to spend at least 80 percent of premiums on health care and quality improvement activities and no more than 20 percent on administrative costs (such as executive salaries and marketing) and profits. In the large group market (generally coverage sold to employers with more than 50 employees), insurers must spend 85 percent of premiums on medical care and quality improvement activities. If they fail to do so, they must provide rebates to their customers.

Next year, additional new rules will help make health insurance more affordable for more Americans.[6] Most health insurance companies will be prohibited from charging higher premiums to applicants because of their current or past health problems or gender, and will be limited in how much more they can charge Americans based on their age.

All non-grandfathered policies in the individual and group markets will be required to enroll individuals, regardless of health status, age, or gender and will be prohibited from refusing to renew coverage because an individual or employee becomes sick. Plans and issuers will also be prohibited from putting annual dollar limits on essential health benefits.

Soon, consumers will be able to select an insurance plan with confidence that it will cover key health care services when they need them. All non-grandfathered policies in the individual and small group markets will cover essential health benefits, which include items and services in ten statutory benefit categories.[7]

Beginning in 2014, non-grandfathered health plans in the individual and small group markets will provide coverage in one of several standardized tiers. These tiers will allow consumers to compare plans with similar levels of coverage, which, along with comparing premiums, provider networks, and other factors, will help consumers make more informed decisions.

[5] Medical Loss Ratio Final Rule: https://www.federalregister.gov/articles/2012/05/16/2012-11753/medical-loss-ratio-requirements-under-the-patient-protection-and-affordable-care-act
[6] Health Insurance Market Rules: http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf
[7] Essential Health Benefits: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm

Improving Access to Health Insurance: The Health Insurance Marketplaces

It is important to remember that most Americans currently receive health insurance through employer-based coverage, or other insurance programs, such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or veterans' health benefits provided through the Department of Veterans Affairs. These sources of coverage will continue with the additional protections and benefits described earlier. Additionally, millions of the over 40 million Americans under the age of 65 who do not currently have health insurance will gain access to affordable coverage.

Establishing the Marketplaces

To give Americans a better way to shop for coverage, the Affordable Care Act supports states in establishing Marketplaces by January 1, 2014. In a state that does not operate such a Marketplace, the Affordable Care Act directs the Federal Government to do so, referred to as a Federally-facilitated Marketplace. A State may also choose to partner with the Federal Government to operate a Marketplace. The Marketplace will provide consumers with access to health care coverage through private, qualified health plans, and consumers seeking financial assistance may qualify for insurance affordability programs.

When consumers visit the Marketplace through HealthCare.gov beginning on October 1, 2013, they will experience a new way to shop for health insurance coverage. There, they can fill out one application to purchase coverage through a qualified health plan, to qualify for premium tax credits and reduced cost-sharing, or to apply for coverage through Medicaid or CHIP.[8] If they live in a state that is operating its own Marketplace, HealthCare.gov will provide a link to the state's website. In recent weeks, CMS has posted information on HealthCare.gov to prepare consumers to shop for quality, affordable coverage in the Marketplace on October 1, including a "Marketplace Application Checklist," which includes the Employer Coverage Tool,[9] a one-page

[8] Application Elements: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html

[9] http://marketplace.cms.gov/getofficialresources/publications-and-articles/marketplace-application-checklist.pdf

form that makes it easier for consumers to seek information from their employers on the coverage their employer offers.

The online version of the application will be a dynamic experience that shortens the application process based on individuals' responses. The paper application is three pages for individuals, and seven pages for families. These applications are much shorter than industry standards for health insurance applications today. The paper application was simplified and tailored to meet personal situations based on important feedback from consumer groups.[10] CMS will continue to support consumers as they fill out the streamlined application, including through HealthCare.gov and a toll-free call center, which is already up and running.

Making Health Insurance More Affordable

We are already seeing evidence that the Marketplace is encouraging plans to compete for consumers, resulting in affordable rates. While some states are still finalizing or finishing final review of their rates, many, like New York, California, Washington, Vermont, Oregon, and the District of Columbia, have released preliminary rates, and in some cases, independent experts say that these rates have been lower than expected.[11] In the sixteen states[12] for which data are available, the preliminary rate for the lowest-cost silver plan in the individual market in 2014 is, on average, 19 percent less expensive than the estimate based on projections by the Congressional Budget Office (CBO).[13] Outside analysts have reached similar conclusions. A recent Kaiser Family Foundation report found that "while premiums will vary significantly across the country, they are generally lower than expected," and that fifteen of the eighteen states examined would have premiums below the CBO-projected national average of $320 per

[10] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-04-30.html

[11] http://www.zanebenefits.com/blog/bid/301885/Washington-Health-Insurance-Exchange-Rates-Lower-Than-Expected and http://articles.chicagotribune.com/2013-05-17/news/sns-rt-us-usa-healthcare-exchangesbre94g0sb-20130517_1_health-insurance-insurance-marketplaces-premiums

[12] The states are: California, Colorado, Connecticut, District of Columbia, Maine , Maryland , Nevada, New Mexico, New York, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Virginia, and Washington.

[13] ASPE Research Brief: Market Competition Works: Proposed Silver Premiums in the 2014 Individual and Small Group Markets Are Substantially Lower than Expected – see: http://aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/ib_premiums_update.pdf

month.[14] We are working with insurers to prepare information for consumers about the coverage the insurers will be providing through the Federally-facilitated marketplaces, so that consumers are prepared to knowledgeably shop for coverage on October 1.

This is good news for consumers. In fact, some insurers lowered their proposed bids when they were finalized. In Washington, D.C., some issuers have reduced their rates by as much as 10 percent.[15] In Oregon, two plans requested to lower their rates by 15 percent or more.[16] New York State has said, on average, the approved 2014 rates for even the highest coverage levels (gold and platinum) of plans individual consumers can purchase through its Marketplace – called New York State of Health: The Official Health Plan Marketplace – represent a 53 percent reduction compared to last year's direct-pay individual market rates.[17] Furthermore, states are using their rate review powers to review and adjust rates accordingly. In Oregon, the state has reduced rates for some plans by as much as 35 percent,[18] and in Maryland, the state has reduced some rates by almost 30 percent,[19] offering consumers an even better deal on their coverage for the 2014 plan year.

In addition to the more affordable rates resulting from competition among insurers, insurance affordability programs, including premium tax credits and cost-sharing reductions, will help many eligible individuals and families, significantly reducing the monthly premiums and cost-sharing paid by consumers. Premium tax credits may be paid in advance and applied to the purchase of a qualified health plan through the Marketplace, enabling consumers to reduce the upfront cost of purchasing insurance. Cost-sharing reductions may also lower out-of-pocket payments for deductibles, coinsurance, and copayments for certain eligible individuals and families. A recent RAND report[20] indicated that, for the average Marketplace participant

[14] http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf
[15] http://hbx.dc.gov/release/dc-health-link-applauds-aetna-decision-cut-rates
[16] http://www.oregonlive.com/health/index.ssf/2013/05/two_oregon_insurers_reconsider.html
[17] http://www.governor.ny.gov/press/07172013-health-benefit-exchange
[18] http://www.oregonlive.com/health/index.ssf/2013/06/oregon_slashes_2014_health_ins.html
[19] http://www.kaiserhealthnews.org/stories/2013/july/26/maryland-marketplace-premiums-exchange.aspx
[20] http://www.rand.org/content/dam/rand/pubs/research_reports/RR100/RR189/RAND_RR189.pdf

nationwide, the premium tax credits will reduce out-of-pocket premium costs by 35 percent from their unsubsidized levels.[21]

CBO has projected that about 8 in 10 Americans who obtain coverage through the Marketplaces will qualify for assistance to make their insurance more affordable, an estimated 20 million Americans by 2017.[22] A family's eligibility for these affordability programs depends on its family size, household income, and access to other types of health coverage.

Spreading the Word

Educating consumers and businesses about the benefits that Marketplaces have to offer is the first step toward helping them take advantage of those benefits. We know quite a bit about the uninsured Americans we need to reach—many have never had health insurance, so the transaction of selecting, applying, and enrolling in health coverage will be unfamiliar to them. According to a CMS analysis of the 2011 American Community Survey,[23] 20 percent of uninsured adults have not completed high school. To effectively reach these populations about their new health insurance options, information should be provided in multiple ways, including by trusted people connected to the community in an appropriate manner.

For that reason, the Affordable Care Act authorizes, and CMS is implementing, a variety of outreach, education, and enrollment assistance initiatives. We are leveraging forms of assistance that exist in the insurance market today, as well as new forms of assistance provided by the Affordable Care Act, to help educate Americans about the options for enrolling in affordable, high quality coverage beginning on October 1, 2013.

In June of this year, CMS re-launched its consumer-focused HealthCare.gov website and the 24-hours-a-day consumer call center to help Americans prepare for open enrollment and ultimately sign up for private health insurance. These tools will help Americans understand their choices and select the coverage that best suits their needs when open enrollment in the

[21] This is a simple calculation based on Figure 6 of the RAND study, available at the link above.
[22] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf
[23] Data set available: https://data.cms.gov/dataset/The-Percent-of-Estimated-Eligible-Uninsured-People/9hxb-n5xb

Marketplace begins.[24] Until the start of open enrollment, the Marketplace call center will provide educational information, and beginning October 1, 2013, it will assist consumers with application completion and plan selection. Additionally, consumers will be able to report suspected incidents of fraud to the call center.

States are using their own marketing efforts to help spread the word on the importance of insurance, especially for young adults. States are tailoring their message to specific audiences and the populations of their states. Recent news reports have highlighted the unique ways Oregon, Kentucky, Colorado, and Connecticut plan to enroll consumers in their Marketplaces.[25] As with the roll-out of expanded healthcare coverage options in the past, such as Medicare Part D and CHIP, other Federal agency partners and members of the private sector are involved in efforts to reach, engage, and assist potential enrollees.

In addition to outreach and education through HealthCare.gov, our toll-free number, and state outreach efforts, consumers in the Marketplace will be able to get in-person help from Navigators and similar in-person assisters, who will provide information to consumers about health insurance, the Marketplace, qualified health plans, and public programs including Medicaid and CHIP. In July, CMS finalized a rule outlining the standards for Navigators, in-person assisters, and certified application counselors in the Federally-facilitated and State Partnership Marketplace. Navigators are trained to provide accurate and impartial assistance to consumers shopping for coverage in the new Marketplace, including consumers who are not familiar with health insurance, have limited English proficiency, or are living with a disability. State-based Marketplaces have the option of using materials developed by the Federally-facilitated Marketplace or creating their own. Navigators will be required to adhere to strict privacy and security standards – including those concerning the protection of consumers' personal information. Navigators also will be required to complete approximately 20 hours of training to be certified, may take additional training throughout the year, and will renew their certification annually.

[24] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-06-24.html

[25] http://capsules.kaiserhealthnews.org/index.php/2013/07/state-insurance-exchanges-launching-tv-ads-to-encourage-enrollment/

To be eligible to receive a Navigator grant, as required in the Affordable Care Act, an applicant had to demonstrate that it had existing relationships or could readily establish relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan. In addition to the rules set forth in the law, funding announcement, and regulations, like other entities and individuals seeking to conduct business with the Federal Government, recipients of Navigator grants were subjected to a robust screening process before the grants were awarded.[26] Awardees must also meet any licensing, certification, or other standards prescribed by the state or Marketplace, if applicable, so long as these state Navigator standards do not prevent the application of Title I of the Affordable Care Act. Fourteen states with Federally-facilitated Marketplaces have set additional requirements for Navigators.[27]

Last month, CMS announced $67 million in grant awards to 105 Navigator grant applicants. Here are just a few examples of the grant recipients:[28]

- Ascension Health, the nation's largest Catholic and nonprofit health system. The Ascension Health Navigator project will assist consumers (individuals and small employers) in understanding new programs, taking advantage of consumer protections, and navigating the health insurance system to find the most affordable coverage that meets their needs.

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[26] Entities and individuals are not eligible for a Federal grant, including a Navigator grant, if they are on the Excluded Parties List of entities or individuals who have been suspended or debarred by any Federal agency. Suspensions from receiving Federal grant money of up to one year may be issued based on indictments, information, or adequate evidence involving environmental crimes, contract fraud, embezzlement, theft, forgery, bribery, poor performance, non-performance, or false statements. Debarments from receiving Federal grant money for a longer period of time may be issued based on convictions, civil judgment or fact-based cases involving environmental crimes, contract fraud, embezzlement, theft, forgery, bribery, poor performance, non-performance, or false statements, as well as other causes. This careful screening will help to ensure that individuals or organizations that pose a risk to the Federal Government are not awarded Federal Navigator grants.

[27] The states are Arkansas, Florida, Georgia, Indiana, Iowa, Louisiana, Maine, Montana, Nebraska, Ohio, Tennessee, Texas, Virginia, and Wisconsin. See http://www.commonwealthfund.org/Blog/2013/Jul/Will-State-Laws-Hinder-Federal-Marketplaces-Outreach.aspx.

[28] http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-8-15-2013.pdf.

- The United Way of Metropolitan Tarrant County has served the people in the Fort Worth and Arlington area of Texas for over 90 years. In collaboration with 17 organizations, it will work across the state to promote enrollment in the Marketplace.
- The University of Georgia's College of Family and Consumer Sciences and Cooperative Extension Service plans to place Navigators in several offices outside the Atlanta metro region. It plans to create awareness through community workshops, to engage a network of existing partners to reach uninsured Georgia residents, and to provide direct services to consumers seeking assistance.
- The Ohio Association of Foodbanks has benefited thousands of people in need in the State of Ohio, since 1991. It will provide outreach support through a variety of phone, online, and promotional tools.
- The Southwest Louisiana Area Health Education Center was founded in 1991 and aims to improve health status in the region through access to information, education and health services. Its current services include programs on career and professional education, health interventions, preventive health, and public health support. It will help to educate Louisianans about their health coverage options .
- The Virginia Poverty Law Center is a non-profit organization that serves Virginia's legal aid system by providing advocacy, training, and litigation support on civil justice issues that affect low-income Virginians based in Richmond. It provides training and technical assistance to the legal aid community and others and works on health care issues with a wide range of statewide organization and partners. It will be working with a statewide consortium of nine well-established programs in the Commonwealth.

Other Application Assistance

Marketplaces will also use certified application counselors, who are volunteers and staff members of other organizations designated by the Department of Health and Human Services. Certified application counselors will help individuals in each Marketplace learn about and apply for enrollment in a qualified health plan and in insurance affordability programs.

More than 1,200 community health centers across the country are preparing to help enroll uninsured Americans in coverage. A partnership with the Institute of Museum and Library Services will help trusted local libraries be a resource for consumers who want information about their options. Also, more than 100 national organizations and businesses have volunteered to help Americans learn about the health care coverage available in the Marketplace, as Champions for Coverage. The growing list of Champions for Coverage is one more example of businesses and organizations across the nation pitching in to help consumers understand the coming options for quality, affordable coverage.

In addition, we have begun training other individuals who will be providing in-person assistance, such as agents and brokers. Over 15,000 agents and brokers have received training from CMS, and that number is increasing each day. All types of enrollment assisters – including in-person assistors, certified application counselors, and agents and brokers – are required to complete specific training and are subject to federal criminal penalties for violations of identity theft or fraud statutes, in addition to any relevant state law penalties.

Conclusion

By making coverage more affordable, improving the value of insurance coverage, and protecting consumers from the worst health insurance industry abuses, CMS is paving the way for a fairer, more transparent, more accessible health insurance system. Over the last three and a half years, CMS and our Federal partners have been hard at work drafting policy, implementing consumer protections, working with stakeholders, and building information technology systems that will enable Americans to shop and apply for health insurance coverage beginning twelve days from now, on October 1. As we work to complete this phase of implementation, CMS stands ready to work with you and your constituents to answer questions about this important law. Thank you for the opportunity to discuss CMS' important work to improve access to affordable health coverage for all Americans.

Mr. MURPHY. Thank you. I now recognize myself for 5 minutes and start out by saying, Mr. Cohen, I want you to understand the function of this committee. Lack of readiness or preparation on your part does not constitute a reason that Congress gives up its responsibilities to have oversight. So I hope you have an open mind as we go through this. You have previously been here at a hearing before. You told us everything was fine. It was like the scene in "Animal House," where the person is saying, remain calm, all is well, while chaos reigns.

So let me ask you a few things here. On July 22 members of this committee wrote to Secretary Sebelius requesting information on the price of health insurance to be offered in the federal and federal state exchanges. HHS still hasn't announced the approved plans and premium prices. Am I correct?

Mr. COHEN. That is true.

Mr. MURPHY. OK. Now, that letter was sent requesting what plans and prices would be available to consumers in the federal exchanges. When will this information be made public?

Mr. COHEN. Consumers will be able to go online and see what plans are available to them on October 1.

Mr. MURPHY. So are you able today with less than 2 weeks before enrollment begin to provide any information on prices and availability for federal exchanges?

Mr. COHEN. My understanding is that we will be putting out some information on rates soon.

Mr. MURPHY. And certainly it is important for the Navigators to know what kind of products they are selling, and training was essential for that. So they do not have this information, yet, either?

Mr. COHEN. Navigators will not be selling any products.

Mr. MURPHY. They will be advising people about products that they can then choose themselves. Am I correct?

Mr. COHEN. They will be advising, providing information, impartial information about consumers' options for purchasing affordable healthcare through the marketplaces. Yes.

Mr. MURPHY. I understand that, which is advising them of the things the person can then choose.

So turning to the Navigators more, now, originally this program was intended to cost $54 million. Correct?

Mr. COHEN. At one time we put out a funding opportunity announcement for $54 million.

Mr. MURPHY. That is right, and then you ended up spending $67 million. Correct?

Mr. COHEN. We increased in order to be able to provide more outreach——

Mr. MURPHY. Right.

Mr. COHEN [continuing]. And more help for people across——

Mr. MURPHY. Well, in June, 2013, a GAO report stated CMS expected to spend $54 million in the program. Are you familiar with that report?

Mr. COHEN. There have been a lot of GAO reports.

Mr. MURPHY. Well, this relates to what you do for a living, so I would hope you would see that one. On July 21, 2013, CMS Administrator, Marilyn Tavenner, wrote to this committee answering some questions we had about the Navigator Program. In that letter

she stated that the Navigator Program would cost $54 million. Two weeks later HHS announced that the Navigator grants would total $67 million, a $13 million increase.

So when did HHS make that decision to increase funding for the Navigator Program? Do you have any idea of the date of that?

Mr. COHEN. I do not.

Mr. MURPHY. And what funding did HHS use for this 13 million increase in the budget for what you do?

Mr. COHEN. I am sure we can get that information for you.

Mr. MURPHY. You have no idea? Suddenly it appeared and you don't know where it came from?

Mr. COHEN. No. I know that we have had an ongoing interest in making sure that we can do as much outreach and help as many people get enrolled in coverage as possible, and additional resources were——

Mr. MURPHY. Yesterday the Administration announced new initiatives to combat fraud under the Healthcare Law by creating a call center along with rapid-response measures to address privacy and cyber security issues. Can you address what these will entail?

Mr. COHEN. I know that we have a call center now. The call center is live now. I think the announcement was that there will be a way for people to report any instances of fraud, and we are working interagency to work with the FDC, for example, to make sure that the appropriate people get that information.

Mr. MURPHY. So you agree the potential for fraud exists then?

Mr. COHEN. There has actually been fraud before the Affordable Care Act, and so this is not the first program that has ever been subject to fraud, and I imagine that there will be fraud that occurs.

Mr. MURPHY. But you are aware it is a possibility, and you are going to watch this very carefully?

Mr. COHEN. We are.

Mr. MURPHY. We will be following up on that. Now, privacy is extremely important. Are the Navigators bound by the HIPAA laws with regard to the laws for healthcare people and——

Mr. COHEN. Well, the Navigators will have absolutely no access to personal health information.

Mr. MURPHY. But they may get some in the process. Someone may say which plan will cover, I have this kind of an illness, I have this sort of problem. They may get that not necessarily soliciting it, and so will there be any laws binding them to confidentiality in not keeping those records.

Mr. COHEN. Well, the terms of the grant and the terms of the cooperative agreement that we have with Navigators spells out very clearly their obligations with respect to keeping——

Mr. MURPHY. Correct, but I know I talked to one navigator group from Pennsylvania who I think is going to do a good job on this because they are already bound by HIPAA laws but not all have that in terms of how they will keep their records, what they will tell employees to do. And so my question is are there any laws in place that prevent people from maintaining or sharing information that may be healthcare related?

Mr. COHEN. So there are, and the Affordable Care Act in particular provides a $25,000 fine per occurrence if anyone uses any information obtained in the course of helping someone.

Mr. MURPHY. That is obligation for the Navigators?

Mr. COHEN. Yes.

Mr. MURPHY. OK. Will Navigators be going door to door?

Mr. COHEN. We will be issuing instructions to Navigators that they should not be going door to door.

Mr. MURPHY. So that will be the ruling you will have with 2 weeks left, they will not be doing that?

Mr. COHEN. That is right.

Mr. MURPHY. They will remain in other public places?

Mr. COHEN. They can't be enrolling anyone now because no one can be enrolling now, so in terms of going door to door to solicit people to enroll in coverage, they will be instructed not to do that, and it is timely because no one can be going door to door enrolling anyone because no one can enroll today.

Mr. MURPHY. Thank you.

I now recognize Ms. DeGette for 5 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman.

Now, briefly, Mr. Cohen, what is the purpose of the Navigator Program?

Mr. COHEN. The purpose of the Navigator Program is to educate people with respect to the benefits under the Affordable Care Act and then to provide objective, impartial help to them if they want it, in finding out what they are eligible for and enrolling in coverage.

Ms. DEGETTE. And can you move your mike a little closer? Thanks. And who decides who these certified Navigators are going to be?

Mr. COHEN. We had a grants process much like every grants process that is——

Ms. DEGETTE. So you had a panel that edited the applications, and they tried to choose people who had experience and some kind of presence in the community. Correct?

Mr. COHEN. First they were screened by the Office of Grants Management at CMS and then there was an independent panel that selected the ones that had scored——

Ms. DEGETTE. OK, and in order to receive a Navigator grant, the applicant has to demonstrate they have existing relationships or could establish relationships with employers. Is that correct?

Mr. COHEN. Correct.

Ms. DEGETTE. And Navigator awardees have to complete a training program, including 20 to 30 hours of an HHS-developed program. Is that right?

Mr. COHEN. That is true.

Ms. DEGETTE. And they have to pass an exam. Is that right?

Mr. COHEN. Yes.

Ms. DEGETTE. And part of that exam includes understanding privacy and affordability programs. Is that right?

Mr. COHEN. Yes.

Ms. DEGETTE. So those people to get the Navigator grants, they have to certify that they are going to comply with any privacy of HIPAA or any other law. Is that correct?

Mr. COHEN. Right.

Ms. DEGETTE. Now, under the Affordable Care Act—let me back up. Right now when somebody signs up before the ACA, when they

signed up for health insurance, people would often have to fill out applications as long as 35 pages. Is that correct?

Mr. COHEN. That is right.

Ms. DEGETTE. And those applications included divulging all kinds of personal medical information because that was necessary for the insurance companies to figure out what the insurance rates, because they could discriminate on pre-existing condition and gender and all kinds of other issues. Right?

Mr. COHEN. Yes.

Ms. DEGETTE. But right now under the ACA none of that pre-existing condition information is even relevant. Isn't that right?

Mr. COHEN. That is true.

Ms. DEGETTE. So to sign up on the marketplaces and exchanges, people aren't even going to have to divulge that kind of information. Is that right?

Mr. COHEN. That is true.

Ms. DEGETTE. So even if a navigator went to the door and was trying to explain to somebody about the exchanges, they wouldn't have to get that information from somebody. Right?

Mr. COHEN. It is not part of the application. Correct.

Ms. DEGETTE. Right, but even if somebody just kind of off-handedly talked about their information, the Navigator would be trained that that is private. Right?

Mr. COHEN. Correct.

Ms. DEGETTE. OK. Now, I want to ask you some other questions about the marketplaces. Now, are the marketplaces going to be up and going on October 1?

Mr. COHEN. They will.

Ms. DEGETTE. Is the federal exchange going to be up and going on October 1?

Mr. COHEN. It will.

Ms. DEGETTE. And that goes, as I understand, people can go on the marketplace for a 6-month period to sign up. Is that correct?

Mr. COHEN. That is true.

Ms. DEGETTE. So if somebody wanted, somebody like, for example, a member of Congress, wanted to go on the federal marketplace and look and see what plans were available, they could go on October 1. Right?

Mr. COHEN. They will.

Ms. DEGETTE. But then they would have some additional time to sort through all those plans and figure out what they wanted. Is that right?

Mr. COHEN. Yes.

Ms. DEGETTE. Now, if they do sign up, their coverage starts January 1, 2014. Is that right?

Mr. COHEN. That is the earliest they can start. Yes.

Ms. DEGETTE. Right. Now, 23 states including Colorado and the District of Columbia are either running their own marketplaces or they are doing a marketplace in partnership with the Federal Government. Is that correct?

Mr. COHEN. Yes.

Ms. DEGETTE. Will those states be ready for enrollment for the start of coverage on January 1?

Mr. COHEN. My understanding from our communications with the states is that all of them will be opening for open enrollment on October 1.

Ms. DEGETTE. OK. Now, can you give me a sense of the milestones and benchmarks that this subcommittee should be looking at to measure the progress over the next few weeks and months, because we keep hauling people in here. Everybody says they are ready. So I would like to know what are the benchmarks that we should be looking for?

Mr. COHEN. Well, I think that there are two types of benchmarks. One are the sort of internal types of benchmarks, how is the call center response time working, how is the Web site working, you know, those kinds of things that just—how are our systems functioning, and then, of course, there are the external—how many people are getting enrolled. I would say that we don't anticipate a huge amount of enrollment necessarily in October because as you've pointed out coverage starts in January, and people have until December 15 to pay their premium.

Ms. DEGETTE. Right. OK, and I guess you are prepared if there are glitches to address those glitches quickly. Is that right?

Mr. COHEN. Absolutely. We are very well mobilized.

Ms. DEGETTE. Mr. Chairman, I just want to say one more thing. I said this before, but when we did Medicare Part D, even though I voted against it and I opposed it, I did outreach to my constituents, and I got my newsletter that I sent out to everybody. I will let you look at it if you want to. We can put it in the record, but I would suggest to everybody on both sides of the aisle, it is incumbent to all of us as elected officials to try to get as many people enrolled in this program as we can who don't have insurance now. I think it would be a good idea. I hope it works, and I think we should all hope it works.

Thank you.

Mr. MURPHY. Thank you, and I hope that all those people from IBM, Xerox, and UPS who have been cut from their insurance plan will be able to look at that.

I now yield 5 minutes to Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. Cohen, if I heard correctly in response to a question from Chairman Murphy, you said that the Navigators would not be going door to door. Is that correct?

Mr. COHEN. The federal grantees will be getting instructions that Navigators are not to go door to door for the purposes of enrolling anyone. Yes.

Mr. BURGESS. Could I ask you? You have an evidence binder there next to you. Could I ask you to turn for a moment to Tab 2 in that binder? All right. In that project abstract summary, so I assume this is the summary that the company or the group provided you in their application to receive monies from the Navigator Grant Program. The second paragraph of that summary reads, "The proposed program will deploy 25 exchange Navigators in each of the targeted counties. Exchange Navigators will seek out uninsured eligible country residents by going door to door."

Is that consistent with your statement to Chairman Murphy that the Navigators would not be going door to door?

Mr. COHEN. Sure. We are going to tell them they shouldn't be going door to door, and I am sure they are going to abide by our terms and conditions.

Mr. BURGESS. But they applied for a grant, and they told you that they are going to seek out eligible individuals by going door to door. Did you read the application?

Mr. COHEN. So first of all I want to say I have never seen this before. I had no role at all in the grant award process, so I am seeing it for the first time now. I understand that that is what they said in there. I see those words. They are going to be instructed from us as part of our agreement with them not to go door to door, and I am confident, Congressman, they will obey that instruction.

Mr. BURGESS. Well, then I have this question for you. Do you know how many money they received in their grant?

Mr. COHEN. I would have to look it up.

Mr. BURGESS. It was $1.2 million. I will help you. My next question is can we have the money back? They provided an application to you which was approved in the Navigator Program and yet they outlined an activity which you said is going to be expressly prohibited.

Mr. COHEN. I am confident they will find other activities that will be very well suited to helping people get enrolled in coverage and that they will be a wonderful grantee.

Mr. BURGESS. I am confident the taxpayer would like to have their $1.2 million back if the grant application was approved based on information which you said would make it ineligible for approval.

Mr. COHEN. I didn't say that, Congressman.

Mr. BURGESS. Let me ask you this, and I have a series of questions, and in the time-honored tradition of this committee, I am going to ask for a yes or no response. Will the enrollment process be ready October 1 of this year?

Mr. COHEN. Consumers will be able to go online, they will be able to get a determination of what tax subsidies they are eligible for, they will be able to look at the plans that are available where they live, they will be able to see the premium net of subsidy that they would have to pay, and they will be able to choose a plan and get enrolled in coverage beginning October 1.

Mr. BURGESS. Let me rephrase the question. Will the enrollment process be ready by October 1 of this year?

Mr. COHEN. I have nothing further to add to my answer.

Mr. BURGESS. Your answer sounded as if it could be a yes but left room for a no. So we will mark down an equivocal response to that question.

Will the excahnges be ready on January 1 of 2014?

Mr. COHEN. Consumers will be able—it is the same answer.

Mr. BURGESS. Consumers will be able——

Mr. COHEN. To go online, get a determinant of what they are eligible for in terms of the subsidy, find out what the subsidy amount is. They will then be able to go and look at the plans that are available to them where they live, and they will be able to—see the premium net of subsidy, and they will be able to choose a plan and get enrolled in a plan beginning October 1.

Mr. BURGESS. And that will be ready on January 1 of 2014?

Mr. COHEN. That will be ready on October 1. That is my understanding. Yes.

Mr. BURGESS. Not your understanding. I need a yes or no answer. You are in charge.

Mr. COHEN. Well, my answer is based on what I have been told by the people who are building the IT System. So it is my understanding.

Mr. BURGESS. Will full implementation of the law on January 1 cause employers to alter or drop coverage for their employees? Yes or no?

Mr. COHEN. I don't know the answer to that question. I know that employers make lots of decisions for lots of reasons.

Mr. BURGESS. OK.

Mr. COHEN. Some having to do with the Affordable Care Act, many having nothing to do with the Affordable Care Act.

Mr. BURGESS. I guess that is a no. Will full implementation of the law on January 1 result in reduced costs for all Americans as routinely promised by their President?

Mr. COHEN. Without accepting your characterization of what the President said, I think what we are seeing that competition in the marketplace is causing competitive rates to be available to many consumers.

Mr. BURGESS. After full implementation of the law on January 1, will all Americans still be able to keep their current coverage if they like it as promised by the President?

Mr. COHEN. Again, without accepting your characterization of what the President said, grandfather plans are allowed to continue to exist without change under the Affordable Care Act. It is up to private insurance companies what products they offer in the market.

Mr. BURGESS. Thank you, Mr. Chairman. I hope we have time for additional questions, but I will yield back at this point.

Mr. MURPHY. The gentleman yields back.

Mr. Dingell, you are now recognized for 5 minutes.

Mr. DINGELL. I commend you for these hearings. It is important that we have proper, friendly, sympathetic, and intelligent oversight to get this program off its feet and going in the direction that we want it to go. This subcommittee has a long and successful record of conducting such oversight, and it has informed the full committee of the Congress of critical facts. Used properly, strong congressional oversight will lead to much good for the American people.

I am fearful that this current investigation into the Navigator Program might be turning into something less desirable, and I hope that we will work together to avoid it. One of Michigan's Navigators is a group called Access, a community-based social services organization I have worked with for more than 40 years. There is nobody that knows our communities better than them, and this is exactly the type of group that we should be empowering to help people sign up for health coverage. They are an institution which believe it or not serves all parts of the society, all racial groups, all religious groups, and does so without discrimination whatsoever.

My questions are going to focus on strong protections that exist in the Navigator Program and the status of ACA implementation. My questions will elicit yes or no answers.

I am assuming, Mr. Cohen, that all of your Navigators meet all of the standards of any Federal Government contractor. Is that right?

Mr. COHEN. It is a grant program. Yes.

Mr. DINGELL. In regards to discipline, integrity, and proper behavior. Is that right?

Mr. COHEN. Yes.

Mr. DINGELL. All right, and I hope as you need you will submit additional answers and responses to the questions for the record.

Are there grants CMS recently awarded to Navigators required by the Affordable Care Act? Yes or no?

Mr. COHEN. Yes.

Mr. DINGELL. Is the training Navigators must go through comparable to the training of agents and brokers who currently sell health insurance? Yes or no?

Mr. COHEN. Yes.

Mr. DINGELL. Does the Navigator training include information as to how to protect the privacy and security of consumers? Yes or no?

Mr. COHEN. Yes.

Mr. DINGELL. Are Navigators subject to the same kind of careful screening as other entities seeking to do business with the Federal Government? Yes or no?

Mr. COHEN. Yes.

Mr. DINGELL. Will the Navigator grantees be overseen in the same way as other CMS grantees are overseen and held to the terms of their grants?

Mr. COHEN. Yes.

Mr. DINGELL. Now I would like to move to talking more about the opening of the new marketplaces which are less than 2 weeks away.

In 2012, were insurers much less likely than in previous years to request rate increases of 10 percent or more? Yes or no?

Mr. COHEN. Yes.

Mr. DINGELL. Would you submit for the record why that is so?

Mr. COHEN. Yes.

Mr. DINGELL. Do you believe that the rate review provision in the Affordable Care Act is a factor which led to this behavioral change on the part of insurers? Yes or no?

Mr. COHEN. Yes.

Mr. DINGELL. Do you believe that the marketplaces are working as intended by making insurers compete over price on the business of consumers? Yes or no?

Mr. COHEN. Yes.

Mr. DINGELL. Is it your expectation that the consumers will have more and better information because of the structure of the marketplaces?

Mr. COHEN. Yes.

Mr. DINGELL. Would you submit some additional thoughts on that, please.

Now, in the 16 states for which we have data, our preliminary rates for health insurance in the marketplace, 19 percent less expensive than predicted.

Mr. COHEN. Yes.

Mr. DINGELL. Would you submit additional comments on that point, please.

Have some insurers submitted bids to participate in the marketplace only to revise these bids and reduce their prices when other insurers' rates came in lower? Yes or no?

Mr. COHEN. Yes.

Mr. DINGELL. Would you submit additional information on that question, please.

Will nearly half of consumers likely be able to pay $100 or less per person for coverage in 2014? Yes or no?

Mr. COHEN. Yes.

Mr. DINGELL. Would you submit additional information for the record on that point, please.

Now, is it correct that eight and ten marketplace consumers are expected to qualify for subsidies to make health coverage more affordable? Yes or no?

Mr. COHEN. Yes.

Mr. DINGELL. Would you submit additional comments on that, please?

Now, we are just a few days away from seeing the full implementation of the Affordable Care Act. I know that there may be some bumps in the road, but we are headed for the right direction. American people are suggesting us to set politics aside and work together for the common good. I am hopeful that we will take this as an opportunity to work together in a bipartisan manner. Our constituents expect nothing less than that.

One thing happened the other day. A spokesman for our good friend, former member of this committee, Tom Coburn, now in the Senate, said a government shutdown would be committing ritual suicide on the order of bad strategy, said his communications director in the "National Journal Daily." The idea that we can fully defund ObamaCare through the continuing revelation is a Washington gimmick to advance political funding goals.

I yield back the balance of my time.

Mr. MURPHY. The gentleman's time has expired.

I now recognize Mr. Olson for 5 minutes.

Mr. OLSON. Thank you, Mr. Chairman, and welcome, again, Mr. Cohen, for returning to answer our questions. I know it is a busy time for you, so I appreciate your time this morning.

Since the last time you appeared before this committee, I have been home talking to the people of Texas 22 about the pending ObamaCare enrollment on October 1. Most hadn't heard of open enrollment. They haven't heard if their employer will continue to provide healthcare under ObamaCare, and now the ones who are working 40 hours per week and working for minimum wage are hearing that they are going to get their wages cut by 25 percent, down to 30 hours or less per week.

But they have heard about Navigators, and they are scared. They have a lot of questions as, you can imagine, they want me to ask you, so please give me a direct response and not a filibuster.

The first question, there are now 104 entities that are Navigators. Is that correct?

Mr. COHEN. I know it is more than 100. That sounds right.

Mr. OLSON. OK. We will assume that is correct. How many of these Navigators have hired people for the Navigator position or currently have people in place to be Navigators that fulfill these requirements? Any idea?

Mr. COHEN. Oh, I don't have the answer to that, but I am sure we can work with you to get you that information.

Mr. OLSON. So we are 7 business days away from this. We have no idea how many Navigators, how many people have been hired as Navigators.

Mr. COHEN. No. I didn't say that. I said I don't know, but we have project officers that are in contact with the Navigators on a regular basis and at least weekly, and I am sure we have that information and would be happy to work with you to get it to you.

Mr. OLSON. About the ones that have been hired, now, you don't know that, but do you know how many have completed or begun their training yet?

Mr. COHEN. I do not know.

Mr. OLSON. OK. About their training, can you provide me some details about their training? I understand it is a 20-hour syllabus, and there is some exam at the end. Is that a multiple choice? How does that exam work? Some details about the qualifications process.

Mr. COHEN. It is an open book. It is a 20-hour exam. It is an online course. You go through the course. As you go through the course, you're asked questions about the material, and you have to score an 80 percent on each section in order to pass and get certified.

Mr. OLSON. Are applicants required to undergo background checks like I am sure you did to have your job, like I did in the Navy? Did Navigators have to have a background check?

Mr. COHEN. So the organizations obviously went through a very rigorous scrutiny process in order to receive the grants. The Federal Government has not required that background checks for the individuals be given, but some states have adopted that as a requirement as they are permitted to do.

Mr. OLSON. And so the people on the street aren't required to get background checks? You are telling me that the entities of employment are, but the people actually knocking on doors, not knocking on doors but getting information out, are not required to have a background check?

Mr. COHEN. Like the CHIP Program, there is no federal requirement for there to be background checks. People have been helping people with Medicare for many, many years, no background check requirement by the Federal Government. States, like the CHIP Program, are able to impose that requirement if they think that is something that is important in their communities.

Mr. OLSON. How about a drug test? You can't get a job out in the Texas oil fields without a drug test. How about a Navigator?

Mr. COHEN. There is no requirement that individual Navigators be subject to a drug test. No.

Mr. OLSON. How about guidelines? How much do Navigators get paid, the people out in the streets? Any idea what the range of their salary is?

Mr. COHEN. It is determined by each of the grantees. It is part of the budget that they presented, and the budget proposals were subject to review by the Office of Grants Management at CMS like every grantee to make sure that the amounts being paid were reasonable.

Mr. OLSON. Does the program have some quality assurance checks, like a so-called secret shopper, somebody that checks up and sees what they are being told is accurate? Do you have some sort of program to make sure that people give accurate information? Are you checking up on that?

Mr. COHEN. We will be doing ongoing monitoring and oversight of the Navigator Program, and it could include secret shopper.

Mr. OLSON. And one final question. I was a panelist for the Chamber of Commerce Board back home talking about the rollout of ObamaCare, and we had a couple State Representatives from Texas on that panel with me. One said that he has heard that the Navigators who are hitting the streets will have voter registration cards. Have you heard that? Is that true or false?

Mr. COHEN. The Federal Voter Registration Law requires that any, that a public program like Medicaid, any application, people be given, offered information about voter registration. That is a federal law requirement, and because the application covers both Medicaid and CHIP and subsidies under the exchanges, we are required to provide information about voter registration to people.

Mr. OLSON. Thank you. I am out of my time, and I yield back.

Mr. MURPHY. Thank you. I now recognize Ms. Castor for 5 minutes.

Ms. CASTOR. Well, thank you, Mr. Chairman, and thank you for calling the hearing.

Mr. Cohen, we are not even in the month of Halloween and yet the Republicans, one of their favorite scare tactics that we hear regarding the ACA is that the Affordable Care Act is going to lead to higher health insurance premiums and rate shock, but while my Republican friends have made every effort to convince Americans that everyone's health insurance premiums are going up on January 1, now we have the data that demonstrates that that is untrue. These assertions that health insurance rates are going up simply is not borne out by a number of analyses that have been conducted.

So let's walk through the information on the Affordable Care Act health insurance premiums, starting at the beginning. Mr. Cohen, when people shop for coverage through the marketplaces, they will be able to compare plans and then select a plan, sign up for the either private insurance or if they have a state that expanded Medicaid, Medicaid. Is that correct?

Mr. COHEN. That is right.

Ms. CASTOR. And if they have a household income below 400 percent of the poverty level, so if you are an individual at about $46,000 or a family of four at about $94,000 on a sliding scale, you will be eligible for tax credits. Is that correct?

Mr. COHEN. That is right.

Ms. CASTOR. Or Medicaid possibly.

Mr. COHEN. Correct.

Ms. CASTOR. Well, this week HHS released an analysis and census data on the 41 million uninsured Americans. Twenty-five percent of Floridians are uninsured. So you can see why these new marketplaces will be a Godsend for them, but 41 million uninsured Americans who will be eligible to enroll in coverage through the marketplaces. Can you tell us in broad terms what the analysis said?

Mr. COHEN. The analysis said that about eight in ten will be eligible for tax credits through the marketplaces.

Ms. CASTOR. And did it say 23 million will be able to purchase coverage for less than $100 a month?

Mr. COHEN. That is correct, including the subsidy. Yes.

Ms. CASTOR. I mean, that is pretty remarkable. Did you have an idea that the coverage would be that affordable?

Mr. COHEN. You know, I think there were lots of predictions about what rates would be. I think we have been just enormously pleased that the marketplace and competition is working, and we are seeing the availability of low-cost, affordable plans in many places throughout the country.

Ms. CASTOR. And these findings have been echoed in recent studies by the non-partisan RAND Corporation and the non-partisan Kaiser Family Foundation, two of the most respected, non-partisan health policy analysts. Are you familiar with these studies from RAND and Kaiser?

Mr. COHEN. I am generally. Yes.

Ms. CASTOR. Tell us in broad terms what those studies found?

Mr. COHEN. Well, Kaiser Family Foundation estimated that in the 18 rating areas, so that is specific geographic locations that they looked at, 15 would have premiums below the latest projections that the CBO had made of what rates would be, and they talked about a premium for a 40-year-old in the second lowest called Silver Plan being $320 a month nationally. That is before the application of subsidies.

Ms. CASTOR. And, Mr. Cohen, are the plans available on the Affordable Care Act in the marketplaces, are they a good deal for the quality of coverage that is being offered?

Mr. COHEN. Well, that is one of the most important things because these plans all have to have the essential health benefits that are required by the Affordable Care Act, and they cannot have annual limits or lifetime limits. So they are going to be there to provide coverage when people need it.

Ms. CASTOR. And at the beginning of the hearing I shared with you and my colleagues the enthusiasm at home, especially among many of our neighbors who have chronic conditions that have been barred from insurance coverage. If you have had diabetes or I talked with a gentleman with multiple sclerosis, HIV, AIDS. I mean, we all have neighbors or family members that have been barred from coverage because of these pre-existing conditions, and this is really going to, like I said, it is giving them hope. They can finally now obtain coverage, and so will this high-quality coverage that is available for the same price, will it be available for the same price even for many of our neighbors that have those pre-existing conditions?

Mr. COHEN. That is exactly right. They cannot be charged more because of the pre-existing condition.

Ms. CASTOR. So every Republican announces premiums under the ACA. If you noticed, they ignore these key facts that coverage has gotten better, that bar against discrimination for our neighbors who have these pre-existing conditions now will go away for 129 million Americans, and they ignore the tax credits. In my State of Florida they said, let's conduct a study, and we will show you that it is not affordable, but then they didn't build into the study the tax credits that are available for families and neighbors and small businesses, too. And then the one that really takes the cake, do you know in my home state, I love my state, but we need help when it comes to healthcare coverage, but one of the things they did that probably wins the award for obstruction and sabotage is they actually took away the Insurance Commissioner's ability to regulate rates and negotiate rates.

Is there any other state that has done that to your knowledge?

Mr. COHEN. I don't believe so, and I was a State Regulator as General Counsel to California Insurance Department, and I know Kevin McCarty very well, and it is an excellent insurance department, and it is unfortunate that their authority was taken away.

Ms. CASTOR. Thank you very much.

Mr. MURPHY. The gentlelady's time has expired.

Now got Mr. Johnson of Ohio for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Cohen, first of all, good morning. Thank you for being here today.

First question for you, whose department is responsible for overseeing and administering these grants to the Navigators?

Mr. COHEN. It is a combination of my office and our Office of Grants Management, both within CMS.

Mr. JOHNSON. OK, but you are responsible for overseeing that process. Correct? You are the director.

Mr. COHEN. When you say process——

Mr. JOHNSON. Yes. The grant process.

Mr. COHEN. The process of selecting the grantees or the process of overseeing the grantees and their work?

Mr. JOHNSON. Process of overseeing and selecting.

Mr. COHEN. Well, so I personally had no role in the selection process. We do that through an independent review panel.

Mr. JOHNSON. OK, but you oversee it. Correct?

Mr. COHEN. Well, I had no role on the selection process.

Mr. JOHNSON. No. Who oversees the grant process? What is your role in the grant process?

Mr. COHEN. So in the grant selection process I had no role.

Mr. JOHNSON. What is your role in the grant process? I didn't say the grant selection process. What is your role in the grant process?

Mr. COHEN. My office is responsible for overseeing the grantees' performance now that they have received the grant.

Mr. JOHNSON. OK. Did you review the criteria for the grant applications to be reviewed?

Mr. COHEN. I did.

Mr. JOHNSON. You did? OK. Well, because earlier when you were asked, you said I don't know. Repeatedly you said I don't know, didn't have anything to do with that.

Mr. COHEN. No. That is not what I said. I didn't review the applications. I certainly was part of putting together what the program would be because that is part of my job but——

Mr. JOHNSON. OK. The criteria for reviewing the grants—you stated in your answer to Dr. Burgess that when he asked you if we could get the money back for those that are doing processes like door to door that are going to be prohibited, you said that you were confident that they would find other activities.

You know, I find this rather an odd way of going about spending the taxpayer dollars because, I mean, if you don't know where you are going, obviously any road will get you there. This is consistent with the theme of let's pass the healthcare law so we can see what is in it. Now you are trying to tell the American people that we ought to award millions of dollars in grants and then find out how they are going to spend it. I would submit to you that that is exactly the kind of irresponsible governance and irresponsible administration that the American people have become so frustrated with. And leaders who purport themselves to be directors, head of agencies that fane, I don't know, and try to shrug our shoulders and say, I didn't have anything to do with that, it is disingenuous, Mr. Cohen.

Mr. COHEN. Well, I respectfully——

Mr. JOHNSON. First question, when you were evaluating——

Mr. COHEN [continuing]. Disagree with your characterization of what I said.

Mr. JOHNSON. Reclaiming my time, Mr. Cohen. Let me ask you a question. When you were evaluating the Navigator Grant Program, were there standards on the appropriate amount of grant spending per enrollee or per individual contacted about enrollment? You told me you reviewed the criteria, so were there any standards about that?

Mr. COHEN. I reviewed the criteria for the program. I was——

Mr. JOHNSON. Then you should answer yes or no.

Mr. COHEN [continuing]. Not involved in the budget discussions with each grantee over what their costs would be.

Mr. JOHNSON. Was there in the grant process, you told me you reviewed the criteria, you just got done saying that, were there any standards on the appropriate amount of grant spending per enrollee? That is a very simply question.

Mr. COHEN. And I don't recall.

Mr. JOHNSON. You don't recall. You don't know.

Mr. COHEN. I don't recall.

Mr. JOHNSON. It goes back to my first statement. Were there any standards or minimums on the number of health fairs attended or individuals contacted via advertisements?

Mr. COHEN. I doubt that the funding opportunity announcement was——

Mr. JOHNSON. Tell me what you know about the criteria. You reviewed the criteria. Tell me what you know about the criteria.

Mr. COHEN. We put out a funding opportunity announcement that describes the program.

Mr. JOHNSON. No. I don't want you to tell me what you did. I want you to tell me what the criteria was. What is the criteria for a grant?

Mr. COHEN. I don't know how to answer that.

Mr. JOHNSON. You don't know.

Mr. COHEN. I don't know how to answer your question.

Mr. JOHNSON. No, you don't know.

Mr. COHEN. No.

Mr. JOHNSON. And that is appalling to me. Turn to Exhibit 1, please. I think it is reprehensible that you would come before the American people as a director of a department and you don't know. You sit there and tell me that you reviewed the grant process, you reviewed the criteria, and yet you don't know. You can't give the first sentence about that criteria.

Turn to Exhibit 1, please.

Mr. COHEN. I have it.

Mr. JOHNSON. OK. This is a Navigators grant application provided to the committee by the Administration. It shows a Navigator applicant who expects to facilitate enrollment of 312 people into qualified health plans. You awarded this organization approximately $80,000 of taxpayer money for only 300 people. Now, I acknowledge you said you didn't have anything to do with the grant award, but you set up the criteria.

Do you believe that this is an efficient use of taxpayer dollars? I can do the quick math.

Mr. MURPHY. The gentleman's——

Mr. JOHNSON. It is $266 per person.

Mr. MURPHY [continuing]. Time has expired. We may go to a second round, so if you have more questions, I will let you come back to it.

Mr. JOHNSON. Am I——

Mr. MURPHY. We will let you answer.

Mr. JOHNSON. Oh, I am not even checking the clock. Sorry, Mr. Chairman. I yield back.

Mr. MURPHY. We can go back.

Mr. COHEN. As I said I literally have not seen this before today. I am happy to go back and look at it and answer your questions. I just can't do that today.

Mr. JOHNSON. I am not surprised you haven't seen that information. I am not surprised at all.

Mr. COHEN. Because I was not part of the grant application and award process for reasons that I am sure you will understand.

Mr. MURPHY. We will follow up with that.

Mr. Waxman is now recognized for 5 minutes.

Mr. WAXMAN. Mr. Cohen, do you approve the budgets of the Navigators?

Mr. COHEN. I did not.

Mr. WAXMAN. No. Do you?

Mr. COHEN. No, I don't personally.

Mr. WAXMAN. You don't. Your agency doesn't?

Mr. COHEN. Yes.

Mr. WAXMAN. Your agency does.

Mr. COHEN. Yes.

Mr. WAXMAN. OK. So what you did is help establish the criteria for awarding these grants to Navigators who will help people know what insurance options are available to them and help them sort through a new law that they have heard a lot of negative things about from partisan Republicans who want to demonize the idea that people will be able to get insurance. I think that the questions you just had were off the mark and not appropriate for Congress. I don't think we ought to beat up on people because they don't like the law.

So the criteria is to select people who can do the job as Navigators. Right?

Mr. COHEN. Yes.

Mr. WAXMAN. And you have something to do with that?

Mr. COHEN. Correct.

Mr. WAXMAN. OK, and then the grants that are made to different applicants to be the Navigators, who decides that?

Mr. COHEN. We have a process where our Office of Grants Management, this is the same as every grant, CMS awards a lot of grants.

Mr. WAXMAN. Yes.

Mr. COHEN. Every grant goes through a screening process where they review the application, they review the management of the applicant, they review the budget, they score them. That then goes to an independent review committee that makes the selections based on the criteria and the purposes of the program.

Mr. WAXMAN. So no one has basis for criticizing you for what an independent grant committee reviews and decides. Isn't that correct?

Mr. COHEN. I agree with you.

Mr. WAXMAN. OK. Look, I don't even know what this hearing is all about. We have had so many hearings by the Republicans to beat up on the Affordable Care Act. They don't like it. I got the idea. When they wanted to repeal it, they could have gotten the message out by asking us to vote for it five times. Instead they voted 41 times. It is because they have nothing else to do but attack this Affordable Care Act. And why do they want to do that? Because they want to confuse people. They want to scare people. That is what this hearing is all about, and in fact, the people who are doing the work of Navigators they are called, are now being intimidated by the Republicans, who are getting a long list of questions, asking them did they do something wrong, I gather. That seems to me so unfair. You have got a clinic, you have got people that work in a homeless shelter, you have got people who work with an ethnic community, people who are there in the community and know the community well, and they have been selected and had to go through tests and classes to be good Navigators, and they are going to do their job. And now they get letters from members of Congress asking them to fill out answers to a long list of questions. Do you know what kind of questions they have been asked?

Mr. COHEN. They have been asked very detailed questions about both the application process and about what their plans are for what they are going to do before they have even started work, before they have even hired their staff.

Mr. WAXMAN. This is nothing but intimidation by this committee. Congress has a lot of power. When the Chairman or a member gets the chance to ask questions, that is a lot of power, but what we need to do is restrain ourselves from abusing that power, and I haven't seen much restraint around here, and I understand one Navigator has already dropped out of the program because they just said we don't have enough money to do the work of answering questions from Congress as well as reaching out to the community. Isn't that right?

Mr. COHEN. Yes. That is true, and I have heard from others that are very concerned. They don't know what to do with, in response to this, to these inquiries that they have gotten.

Mr. WAXMAN. I just think this is such an abuse of power to intimidate Navigators who are going to explain the new law to people. In California we are running the program, and we license people who sell private insurance, and the state has taken over the responsibility of approving the Navigators, hasn't it?

Mr. COHEN. Yes.

Mr. WAXMAN. So they have a job to do, they have been checked out to be sure they are people who are capable of doing the job. We don't call in private insurance salesmen to ask them a whole bunch of questions, but when they are trying to just get the community to understand something new, this committee abuses its power and wants to ask all sorts of questions, and at a time when they are trying to run this program with a couple of weeks left before the opening of the exchanges.

Mr. COHEN. And I would just add if I might that any state that wanted to run their Navigator Program had the ability to do that either by operating its own marketplace or by being a consumer assistance partner with us. They could have taken over the whole thing.

Mr. WAXMAN. Well, my state is doing a good job. We are going to have a great success in California. I think we are going to have success around the country unless Republicans intimidate people, whether it is at the state level or the federal level, to scare them about the idea that they can get insurance that has been denied them in the past, and the Republicans said nothing about it but denied them in the past because they had pre-existing medical conditions——

Mr. MURPHY. The gentleman's time has expired.

Mr. WAXMAN [continuing]. Or they couldn't afford the insurance policy. And so I don't know what this hearing is all about except to intimidate people, and I resent it, Mr. Chairman, and I resent the kind of questions that our witness has just been subjected to by my colleague.

Yield back my time.

Mr. MURPHY. Yield for question and query. You had made a reference to California is taking over these things, and they also have laws for insurance agents who sell these policies.

Mr. WAXMAN. Yes.

Mr. MURPHY. Are you saying that it would be under the same guidance or rules or regulations as an insurance agent? Could you clarify that for the record?

Mr. WAXMAN. Well, Mr. Cohen could probably do it better, but as I understand it, California is going by the standards set by the Federal Government. Isn't that right? Why don't you answer?

Mr. COHEN. California because it is operating its own marketplace has its own Navigator Program, and it is not requiring Navigators to be agents and brokers. We have issued regulations saying that states may not do that, but it has put in additional requirements above and beyond the federal requirements as states may do.

Mr. MURPHY. Just for clarification I am just confused because I know many states have rules about continuing education, fingerprinting, background checks, licensing tests for agents. So if they are under the California Program they are not going to be part of those same sort of rules? There is a separate level?

Mr. COHEN. I am not 100 percent familiar with what California is doing, but I believe that California is requiring backgrounds checks and fingerprints.

Mr. MURPHY. Could you just let us know?

Mr. COHEN. Sure.

Mr. MURPHY. Thank you very much.

Now recognize Mr. Scalise for five questions—5 minutes.

Mr. SCALISE. Hopefully I can get to more than five questions, but I will do my best to get through the questions I have, and Mr. Chairman, I want to thank you for having this committee. I think it is important that we have oversight over a program that is involving not only $67 million of taxpayer money but a new program where these Navigators, people will be going throughout America trying to sign people up for the President's Healthcare Law that has missed so many deadlines, that has had so many problems. For somebody to kind of insinuate that we should not be asking real tough questions, American people have tough questions. That is why they sent us here. I would hope, Mr. Cohen, you are here to give straightforward answers to the questions that people have, and anybody who thinks that sunshine and transparency will undermine the law, maybe they are right. Maybe the fact the more people find out about this law they don't like it. That is not our fault. That is the fault of such a bad law that the more people find out about it they don't like it.

Mr. COHEN. I always do my best, Congressman, to answer the questions.

Mr. SCALISE. I appreciate that, and do you think any of these are unfair questions?

Mr. COHEN. I think I better not respond to that one.

Mr. SCALISE. Not only are you under oath, but the President that you work for, the President said on a campaign promise that he would be the most transparent President ever, and all of the sudden we start asking basic questions, and people are feigning that we shouldn't be asking tough questions, because, boy, that poor President, it might make his law look bad if people find out just what is in it.

Mr. COHEN. Congressman, I have no problem with answering questions of me. This is the seventh time that I have testified before a Congressional committee or subcommittee since December. I have always done my best to answer the questions. I have always

done my best to provide additional information when I wasn't able to answer the question.

Mr. SCALISE. OK. I just want to make sure——

Mr. COHEN. The concern that I have—so any questions you have for me or for us as a department——

Mr. SCALISE. I want to ask you about background.

Mr. COHEN [continuing]. The concern that I have is for the scrutiny that these Navigators groups were put under even before they ever——

Mr. SCALISE. Let me ask you. If a Navigator——

Mr. COHEN [continuing]. Started their work.

Mr. SCALISE [continuing]. And I want to ask you to get the committee the name of any Navigators who dropped out of the program because of scrutiny, I would ask you can you get that information to this committee?

Mr. COHEN. Yes.

Mr. SCALISE. Because if any Navigator dropped out of the program because they didn't want to be held accountable for the taxpayer money they are receiving, they don't belong in the program. They ought to get out of the program.

Mr. COHEN. That wasn't the reason.

Mr. SCALISE. Well, then let's see the names of those people, and we will follow up.

Mr. COHEN. The reason that it was——

Mr. SCALISE. We are asking real questions. They ought to be providing answers just like you should.

Mr. COHEN. That wasn't the reason.

Mr. SCALISE. They are getting taxpayer money. I want to ask you about criminal background checks. This is a big concern of a lot of people I know in my district and when I talk to colleagues, others. Why is it that you did not choose to include background checks on people that are going to be going around asking people for very secured, personal information about their health?

Mr. COHEN. First of all, they are not going to be asking people information about their health.

Mr. SCALISE. These people will be having——

Mr. COHEN. That is wrong.

Mr. SCALISE [continuing]. Conversations with Navigators about healthcare.

Mr. COHEN. They are not going to be asking——

Mr. SCALISE. They are going to be trying to give them advice, aren't they, about what kind of healthcare options they have in these exchanges? Is that what——

Mr. COHEN. They are not going to be asking people for information about their health. That is not part of the application.

Mr. SCALISE. They will be asking them healthcare questions.

Mr. COHEN. They are not going to be asking them for information about their health. It is not part of the application.

Mr. SCALISE. So let me ask you this. If somebody just got released from prison for a conviction on identity theft, would that person be eligible to be a Navigator? Yes or no? You are under oath.

Mr. COHEN. I am confident that the organizations that we have given grants to——

Mr. SCALISE. Can they be eligible? Are they eligible? It is a yes or no question. I am sure what you hope, if you hope that they are not eligible, why didn't you make that a rule? Am I incorrect in saying that a person who was just released from prison on identity theft can be a Navigator under your rules? Is that an inaccurate statement?

Mr. COHEN. We have had——

Mr. SCALISE. Because I am making that statement right now. Your rules allow someone who committed identity theft to be eligible to be a Navigator. If I am saying anything incorrect, you just correct me right now.

Mr. COHEN. We have had experience for many, many years with the CHIP Program. There was no federal requirement for background checks in the CHIP Program.

Mr. SCALISE. OK. So my statement is correct.

Mr. COHEN. I am not aware——

Mr. SCALISE. If you correct me, then I will stop saying it, but I just made a statement. If I said anything inaccurate, please correct me, but if you don't, I will keep making that statement.

Mr. COHEN. There is no federal requirement for background checks or criminal record checks——

Mr. SCALISE. OK. Stop right there.

Mr. COHEN [continuing]. In the Navigator Program. Some states——

Mr. SCALISE. Was there a concern——

Mr. COHEN. Excuse me.

Mr. SCALISE. No. That is my time. He didn't answer my question.

Mr. WAXMAN. Point of order. The gentleman ought to be given the courtesy to answer the question.

Mr. SCALISE. Well, he will be given the courtesy. I will ask one follow-up question, and then I will let you have the time.

Mr. COHEN. Congressman, I ask for your support here in being able to answer these questions.

Mr. MURPHY. One more question.

Mr. SCALISE. The question I have is were you concerned that invoking criminal background checks might limit the number of people that would apply to be Navigators?

Mr. MURPHY. Mr. Cohen, you may answer the question.

Mr. COHEN. We want to get as many—we had a number of factors. It was not clear to us that we have the authority to require the criminal background checks, and we wanted to make, we left it up to the states to determine whether that was a requirement that they wanted to impose.

Mr. SCALISE. So that was a yes or no question I asked. I would just ask if you could give a yes or no answer to a yes or no question. Were you concerned that invoking criminal background checks might limit the number of people that would apply to be Navigators?

Mr. COHEN. The cost and the difficulty of doing criminal background checks, yes, we were concerned about that.

Mr. MURPHY. The gentleman's time has expired.

Mr. Cohen, would you be able to at some point in the near future provide information on, you said some states have it, some states don't, just so we can have that.

Mr. COHEN. Sure. I would be happy to.

Mr. MURPHY. And those issues are obviously a concern I think from members on both sides of the aisle to make sure that the people coming through are trustworthy.

Now recognize Mr. Tonko for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair, and Mr. Cohen, thank you for returning to the committee and for your diligent work thus far in trying to implement probably the biggest reform to our Nation's healthcare system in our history. This is no small task, and so we all appreciate, I would hope we all appreciate the commitment and grace you have shown in taking on this work, and I have some questions, and I will allow you to answer them and not talk over you.

We have understandably heard a lot already today about the exchanges which are the most visible piece of the ACA. So I wanted to take the time to ask you about some of the other insurance reforms under ACA that your center is responsible for.

Under the ACA the center is charged with providing support to consumers when insurance companies deny payment for a service or treatment which have coverage guaranteed under ACA such as preventative services. One such example of a guaranteed benefit under ACA is BRCA testing and genetic counseling for women meeting certain risk criteria for heredity breast and ovarian cancer.

However, I have heard reports of several women in New York who have been denied BRCA testing despite meeting the criteria for testing and receiving medical advice to have the testing done. My understanding is that this should not happen and that your center is charged with ensuring that it doesn't.

What resources and assistance does the center offer for consumers who need to appeal health insurance claims decisions, and where could consumers gain easy access to these resources?

Mr. COHEN. So there is a requirement under the Affordable Care Act for an external appeal process after someone goes through the process through their insurance carrier, and New York is probably running that appeals process. I would have to go back and look. Some states are doing it. In some cases it is the Federal Government that is doing it if the state doesn't have a process that meets the required standard.

In addition, we work very closely with the state departments and insurance when we learn of something that is a systemic problem, so if it is not just, you know, one particular individual or two, you know, but it looks as though a particular carrier or even more broadly all the carriers in a market or whatever are not abiding by the provisions of the Affordable Care Act, we work very closely with state insurance departments to make sure that they do.

Mr. TONKO. Thank you, and perhaps if you could look more closely at that specific situation, I would appreciate it.

Mr. COHEN. We would be happy to.

Mr. TONKO. As you know, the implementation of the Affordable Care Act will extend federal parity protections from Mental Health Parity and Addiction Equity Act to more than 62 million Americans. However, given the delay in issuing final parity regulations, it is doubtful the American people will enjoy the full protections of

mental health parity consistent with the spirit of that legislation as the ACA goes into full effect in 2014.

With another terrible tragedy unfolding again this week here in DC, the need for a robust national commitment to mental health has been highlighted yet again. We have heard from numerous Administration officials that a final mental health parity regulation would be finished by the end of the year, a date which is rapidly approaching.

Can you provide us with any more details on when to expect any such final parity rule?

Mr. COHEN. So we have committed that there will be a rule out by the end of the year. I am confident there will be. I know work is ongoing. I have been to meetings where we have been reviewing the provisions of the final rule. It is moving through our process. I can't give you an exact date of when it will be coming out, but it will be coming out by the end of the year.

Mr. TONKO. OK, and can you describe in detail the current investigation and enforcement process that your office goes through when it receives a complaint about parity violations?

Mr. COHEN. Sure. So as with many federal law provisions, HIPAA, and mental health parity, again, the states are the principle primary enforcer. So what we typically do when we hear about problems, and we do have a hotline where people can call and, you know, tell us about problems they are having with their insurance company, we generally will reach out first to the state department. There have been some instances since I have been at CCIIO where the state has told us that they are not able to deal with the problem, and we have dealt directly with the insurance companies to make sure that they are complying.

Mr. TONKO. Yes.

Mr. COHEN. We have also done some outreach and education because I know that the requirements of the Mental Health Parity Law are not as well-known and understood, and so we have been doing some outreach and education both to the issuer community and to the state insurance departments to make sure they understand the provisions of the law.

Mr. TONKO. When these investigations, Mr. Cohen, of parity violations are conducted, are the results of these investigations made public?

Mr. COHEN. It depends. What we try to do normally is get compliance, and if we are able to get compliance, then—and there is no administrative action that is begun, then typically that would not be public.

If we go to the point of actually beginning administrative action and the possible imposition of civil monetary penalties, that would be public.

Mr. TONKO. I know my 5 minutes are up, and with that I——

Mr. MURPHY. I recognize Mr. Harper for 5 minutes. Thank you.

Mr. HARPER. Thank you, Mr. Chairman. Mr. Cohen, good to see you again, and I have some questions. If I could get you to look in the notebook and turn to Exhibit 4 for just a moment, please. Exhibit 4. And if you will look at that, you will see that number 14 says, incentives for quality connections and the second sentence states they, meaning Navigators, have the opportunity to earn

$200 additional per quarter if they meet a standard of 300 enrollments or screenings during the quarter. Do you see that?

Mr. COHEN. I do.

Mr. HARPER. Do you believe it is appropriate to pay Navigators for the number of individuals enrolled?

Mr. COHEN. In the federal program we are not permitting Navigators to be paid by the number of enrollments. I understand this is an application, and it may be what they thought that they were going to do, but we are not permitting that.

Mr. HARPER. So what are they getting? Just a straight salary or a straight—so they get paid the same, you are saying. This is not true?

Mr. COHEN. This is an application.

Mr. HARPER. OK.

Mr. COHEN. But I am telling you that in the federal program Navigators are not being paid by the number of enrollees.

Mr. HARPER. OK, but didn't you approve this application?

Mr. COHEN. I did not, but there is a budget process that——

Mr. HARPER. Somebody approved the application.

Mr. COHEN. We did. We did. OK. So there is a budget process that goes through before a grant is awarded, and I don't know the specifics of this particular applicant, but I am confident that the budget that was worked out with this applicant did not include payment per enrollee.

Mr. HARPER. Can you check that——

Mr. COHEN. I can.

Mr. HARPER [continuing]. To be 100 percent sure and get back with us in writing on that?

Mr. COHEN. I would be happy to.

Mr. HARPER. So is there another application, another form that we should be looking at?

Mr. COHEN. Well, there is a grant award, there is a cooperative agreement between the grantee and CMS. Yes.

Mr. HARPER. All right.

Mr. COHEN. This is just the application.

Mr. HARPER. Let me at least——

Mr. COHEN. Part of the application.

Mr. HARPER [continuing]. Let me ask you this. If this were true, would you believe that we should be incentivizing Navigators to go enroll as many people as possible?

Mr. COHEN. In the federal program we made the decision not to permit compensation based on number of enrollees.

Mr. HARPER. OK. Well, but this is a document that you provided to us if I am not mistaken.

Mr. COHEN. It is an application.

Mr. HARPER. OK. Well, and that is what I am referring to is the document. So just so I am clear are you saying then that no Navigator is being paid additional money or bonus money by the number of people signed up? That is what you are saying?

Mr. COHEN. In the federal program. Correct.

Mr. HARPER. All right. Well, what about in any other program or other entity?

Mr. COHEN. My understanding is that there may be some states that are paying some portion of compensation for enrollees.

Mr. HARPER. And you would know which states those are. Correct?

Mr. COHEN. We can get that information.

Mr. HARPER. Would you do that and——

Mr. COHEN. Sure.

Mr. HARPER [continuing]. What amounts and if they are paying all Navigators the bonus based upon numbers, I would want to know that.

All right. Are you going to issue any type of statement or standards for Navigators or to the states directing them not to do this?

Mr. COHEN. No. We have left, I mean, the states as throughout the Affordable Care Act we have given the states a lot of flexibility to design their programs in the way that they think is best for their state, and so we are not telling states that they can't do it. In the federal program Navigators are not being paid per enrollee.

Mr. HARPER. All right. Following up on other questions, my understanding of what you are saying is that Navigators are not subjected to or a criminal background check is not done. Correct?

Mr. COHEN. There is no federal requirement for a criminal background check. Some states are imposing a criminal background check requirement on Navigators.

Mr. HARPER. But it is not your requirement, a federal requirement to do that.

Mr. COHEN. Right.

Mr. HARPER. The Navigators are going door to door in some situations. Correct?

Mr. COHEN. Navigators will be told that they should not go door to door to solicit people to enroll in coverage.

Mr. HARPER. They are being told not to.

Mr. COHEN. Not to.

Mr. HARPER. OK. Do you know if they are doing that on any state level?

Mr. COHEN. I don't.

Mr. HARPER. OK. Can you let us know that, too, please——

Mr. COHEN. I can try to find that out.

Mr. HARPER [continuing]. As one of the things here. If I could get you now to turn to Exhibit number 8. Exhibit 8 is a work plan from one approved Navigator. If you look through, you will see it promises a complete 24,000 robo calls in the first quarter, 72,000 robo calls in the second quarter, another 72 in the third, and 72,000 more in the fourth quarter.

Do you see that document?

Mr. COHEN. Yes.

Mr. HARPER. Do you believe that Navigators should be using taxpayer dollars to fund robo calls?

Mr. COHEN. I am going to have to check to see what our instructions are going to be about that. My understanding generally is that our expectation is that when it comes to enrollment assistance, we are expecting that people are going to come to the Navigators rather than the Navigators going to them.

Mr. HARPER. Sure, but this is an application that was approved. So this was an approved application, was it not?

Mr. COHEN. This grantee was awarded a grant. It doesn't meant that every single thing in the application was, ended up in the final end award.

Mr. HARPER. All right, but they awarded a grant, and that application did call for robo calls that you saw.

Yield back.

Mr. MURPHY. Thank you. The gentleman's time has expired.

I now go to Mr. Green for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. Cohen, let me explain to you the district I represent. I have a very urban district in Houston, and it has some of the highest in the country of uninsured. Hidalgo County in South Texas, the numbers in my district compare to some of the poorest counties in the country. Some of the questions you are hearing in looking at the exhibits, I know my Navigators are not going door to door. They are prohibited from doing it. But Enroll America, which is a non-profit group, is doing that. In fact, I asked them to do that in my district. I want them to be out there making people know that this law is available.

What you are hearing today is folks who don't like the law, and that is OK. They didn't vote for it, but they are trying to keep it from actually working, and in a district like I have, this is the way those folks can go and have insurance for their families.

And so it is frustrating to me when they were talking about, you know, fingerprinting. You know, under state law maybe my insurance agents are fingerprinted and do background checks. I am not sure, but it is not in the federal law to do that, and so in the State of Texas that is not an issue. Now, insurance agents may be able to, but we don't hold these Navigators to a higher standard than the federal law is.

So, again, their complaint is is that they really don't want the Navigators to do their job to sign people up who come in.

Also, I would be offended if I had to ask my insurance agent, by the way, do you have a background check. You know, that is just amazing that some of my colleagues would do it, but, again, their point is they don't like the law, and they are trying to stop, use any way they can to discredit it, but it is working. I did an event in our district. We are doing more events in our district because we want that outreach to be there.

Let me ask you something. One of the questions about the Navigators being paid incentives, and I am looking at Exhibit number 4 on page 10. Navigators are paid a base wage of $10 an hour with the expectation of meeting basic performance guidelines they will have the opportunity to earn $200 more per quarter if they meet 300 enrollment screenings. Federally-qualified health center employees, I know in my district or actually they have physicians to be able to sign people up, we are talking about some of the folks who make some of the lowest wages that we can imagine. And it sounds like to me it would be a Republican thing to incentivize them to actually go out and do it correctly, and that is what I think that is, you know, welcome to Congress.

But let me talk a little bit about one of the issues that have come up, and I have heard it a lot. On the floor last week we were forced to vote on a bill that would force the HHS IG to take an unprece-

dented role of certifying marketplace verification systems before people could get financial assistance. I want to ask you a series of questions about that.

When an individual applies for financial assistance through the marketplaces, what steps are taken on the front end to verify that they are not under-reporting their income in order to get financial assistance?

Mr. COHEN. We check against available sources of data including Internal Revenue Service data, including Social Security Administration data, and if necessary, private employer data through a database that is also part of that system to see whether——

Mr. GREEN. So you have access to the IRS database, and you also can be checked against Equifax, for example, for current information?

Mr. COHEN. That is right.

Mr. GREEN. So there is upfront verification. What about on the back end? If an individual's taxes at the end of the year indicate they are not eligible for that financial assistance, what do they have to do?

Mr. COHEN. The IRS is going to require that they reconcile that at the end of the tax year, and if they have to pay money back, they will have to pay money back.

Mr. GREEN. Well, and I know most folks, the last thing they want to hear is that the IRS is going to come audit you because you claimed less income than you actually earned, and you are going to pay this back. Is there a penalty for them under, I assume under IRS regs? There is probably a penalty that would be added not only to the back taxes but to the penalty.

Mr. COHEN. And in addition, the information that they provide, it says right on the application it is being provided under penalty of perjury and that there are penalties just for submitting false information if it is done, you know, intentionally.

Mr. GREEN. My Republican friends have repeatedly asserted the ACA would be right with fraud and suggested people would be lining up in property to get financial assistance. First of all, the financial assistance provided through the marketplace may only be used to purchase health insurance.

Mr. COHEN. That is right.

Mr. GREEN. It is not correct they get a direct cash assistance or sent to people's homes. That is incorrect.

Mr. COHEN. The money goes directly from—to the insurance company that they have chosen.

Mr. GREEN. The carrier.

Mr. COHEN. Yes.

Mr. GREEN. And since they won't even see the money, it would be credit applied against insurance premiums, it seems unlikely that people are out there waiting to profit from this program and to put money in their pockets when they won't even see the money. Can you tell us about the uninsured who are using the exchanges in particular, and again, the State of Texas, we have to have a national exchange, and I appreciate other states who took the incentives on their own, but I also know HHS is supposed to put more resources in states that don't have a state partner. So I appreciate that coming to Texas.

In particular I want to address the allegation I heard that people who buy insurance in exchanges are fraudsters and deadbeats. Is there any information on that? All people are looking for is to be able to cover their families with healthcare, and this is an opportunity to do it.

Mr. COHEN. They just want to take care of themselves and their families. That is right.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. MURPHY. Thank you, Mr. Green.

Ms. Ellmers, you are recognized for 5 minutes.

Mrs. ELLMERS. Thank you, Mr. Chairman, and thank you, Mr. Cohen, for being with us again. I think you said this is the seventh time. Is that correct?

Mr. COHEN. Not before this committee obviously, but, yes, this is the seventh time I have testified since December.

Mrs. ELLMERS. On the Hill.

Mr. COHEN. Yes.

Mrs. ELLMERS. OK. Well, first off, I do want to go back to one of the comments that you made about how you believe that there is competition that is being created amongst the insurance companies with the exchanges.

You know, very recently, I believe as recent as last week, in North Carolina in my district, First Carolina Care Insurance Company announced that they will not be part of the exchange. They supply health insurance to thousands in my district. This means less options for my constituents and now I believe for North Carolina there are only two insurance companies. How does this provide competition?

Mr. COHEN. So the results are different from state to state. In many states we have seen new entrants coming in and a lot of choice, and in other states we have seen less.

Mrs. ELLMERS. OK.

Mr. COHEN. As I think you probably know, the existing market is extremely highly concentrated in some states.

Mrs. ELLMERS. So but for my, reclaiming my time, my North Carolina constituents, though, will have less competition.

Mr. COHEN. Well, I don't know what's available to them off the marketplace.

Mrs. ELLMERS. Let's move on because they live in North Carolina.

I would like for you to move to Exhibit 7, and this is part of the approved application process. Now, in Exhibit 7 it says that the applicant basically is going to spend money on participant incentives by purchasing and giving out gift cards to obtain consumer feedback on assistance provided and consumer knowledge from the satisfaction of the event.

Do you believe that this is inappropriate use for the Navigators to entice individuals with gift cards?

Mr. COHEN. Well, it doesn't sound as though it is enticing. It sounds like they want to get feedback, and in order to encourage people to give them feedback, they are going to give them——

Mrs. ELLMERS. So are you sure that the idea of the gift card, so you know for sure that they would be basically given the information and then you don't see that as enticement?

Mr. COHEN. That is what it looks like to me from here, but I can check.

Mrs. ELLMERS. So just to clarify, you don't believe that is enticement.

Mr. COHEN. It doesn't look like it. No.

Mrs. ELLMERS. OK. Well, I would like to go back to a couple of the other issues. You know, now we have seen repeatedly that there are many questions based on the letter that we put out asking the Navigators, and of course, you know, those on the other side of the aisle are saying that this is intimidation, and certainly they have quoted me as well, and I don't believe that Congress asking questions and doing oversight is intimidation at all. We are charged with making sure that taxpayer dollars are utilized correctly, and I know that oversight is very important for you as well.

I would like to also go to the point here where it says in a response, and I would like to submit this for the record although we have it, that basically HHS reported that we trust that our responsibility addresses your questions about the Navigator Program and the guidelines and controls in place to monitor the work of the awardees.

Now, there are a number of these situations where you are going to be getting back to us with answers. Is that correct? Some of the different applicants, the questions that have been posed to you. It is unclear at this point how it is being implemented, and you have repeatedly said that you would get back with information and written statements.

Mr. COHEN. Right, and I have no objection or questions whatsoever about——

Mrs. ELLMERS. OK. So I guess——

Mr. COHEN [continuing]. Questions about this program directed to us.

Mrs. ELLMERS. OK. So do you not see that as a basis for a delay at this point, that we would just continue to move on with this process even though it is very, very unclear as to how these applicants are really going to be utilizing good, hard-earned taxpayer dollars?

Mr. COHEN. No, I don't.

Mrs. ELLMERS. So you believe that we should continue as is?

Mr. COHEN. Absolutely.

Mrs. ELLMERS. Regardless of being able to report back to Congress on this issue so that we can make sure that the taxpayers of this country know that their dollars are being utilized?

Mr. COHEN. I don't think that your questions are a basis for delay.

Mrs. ELLMERS. So if I were, I am a taxpayer obviously. So if you were speaking to one of my constituents right now, a little lady that lives down the street from me, would you say based on all of these questions that have been posed that her taxpayer dollars are being utilized well?

Mr. COHEN. Absolutely, and I would say that——

Mrs. ELLMERS. OK. Thank you.

Mr. COHEN [continuing]. She should be very proud——

Mrs. ELLMERS. You have answered my question, but I would also like to submit for the record to the points about the issue of under-

mining and you know, being aggressive in this effort. There is an article in the "Business Journal," Thursday, September 12, 2013, and I would like to submit this for the record, where my office actually reached out to Randolph Hospital who is a Navigator applicantee, and let me just read a quote from them. "From my perspective and the hospital's perspective we just see this as a they are doing their due diligence and making sure the organizations that receive these funds are going to be used, and the funds in the manner in which they were intended, said Devin Griffith, Vice President of Care Continuum and Support Services in Randolph." We don't foresee this as being a problem.

Thank you very much. I yield back the remainder of my time.

Mr. MURPHY. The gentlelady yields back and now our new member, Mr. Yarmuth, is recognized for 5 minutes.

Mr. YARMUTH. Thank you very much, Mr. Chairman. I appreciate the courtesy of the committee, and I am very honored to be a part of the committee, even though it appears I just joined a game of Trivial Pursuit that we are worried about $10 gift cards when we are talking about a law that will affect 300 million Americans.

Before I get into one line of questioning, I would like to plug my home State of Kentucky. Kentucky has embraced the Affordable Care Act. Our governor has taken the opportunity to provide insurance to 640,000 Kentuckians who are currently uninsured. We have an exchange that is a model I think for the country. It is called Kynect, K-y-n-e-c-t, and one of the great ironies of this debate is that during our state fair last month Kynect had a booth. A lot of people curious about what was available to them under the law, and after talking to the people at Kynect they walked away, many of them saying, wow, this is a lot better than ObamaCare. So that is kind of what we are dealing with.

There have been a couple of comments earlier today that related to moves that certain corporations have made, and Republicans have pounced on them as kind of making an argument that they were somehow precipitated by the Affordable Care Act and somehow resulted in a negative outcome.

One of them is UPS. UPS is not based in my district but the global hub is there. They are our largest employer. So when I heard about the fact that they were asking those employees who had spouses who were eligible for coverage through another employer to take their coverage there, and they were going to stop providing dependent coverage to them, that this was somehow something that the Affordable Care Act forced them into. Republicans pounced on that. My Senator Mitch McConnell did. So I talked to the UPS executives about this, and they actually said, no, we are very upset about the way Republicans have used us because what the Affordable Care Act did was allow us to make this business move, which a number of companies have done, and preserve our coverage at current rates and current contributions for our employees, about 15,000 out of the 770,000 lives that they insure.

So it basically was nothing that the Affordable Care Act did that resulted in a negative outcome, but my question to you, Mr. Cohen, is before the Affordable Care Act, could UPS have done what they did?

Mr. COHEN. I am not familiar with that particular circumstance, but I don't believe so.

Mr. YARMUTH. But UPS could have dropped their coverage entirely before the Affordable Care Act?

Mr. COHEN. Oh, of course.

Mr. YARMUTH. UPS could have made any changes they wanted to, could have——

Mr. COHEN. Yes. Yes.

Mr. YARMUTH [continuing]. Given, provided inferior coverage, anything they wanted to.

Mr. COHEN. Correct.

Mr. YARMUTH. And we all know that, I think most of us know that when President Obama said if you like your coverage, you can keep it, what he meant was that nothing in the Affordable Care Act would force an employer to change their coverage. Not that there might not be changes. In fact, some might be an improvement, and the issue of Walgreen's was mentioned earlier today. Walgreen's has decided to set up a private exchange for its employees, not shoving them into any government exchanges, so they have just chosen to make an alternative arrangement for providing insurance for their 160,000 employees. Isn't that correct?

Mr. COHEN. That is what I understand.

Mr. YARMUTH. And when they announced it, they said the reason we were able to do that, the reason we wanted to do it is because of the private exchanges, we can actually take, expand the options that were available for our employees. Right now they said there are only two high deductible plans, so we could improve their situation.

So you could actually make an argument, I think, and I will make the argument that because of the Affordable Care Act and the creation of exchanges and the success that the exchanges seem to project in terms of increased competition and lowering costs, that this gave Walgreen's an opportunity to improve the situation with their employees. Would you agree you could make that argument?

Mr. COHEN. I agree, and I think it is important to recognize that for many, many years employers have been struggling with the ever-increasing costs of healthcare and of health insurance, double-digit increases year after year, and what we have seen in the last few years are significantly lower increases in the cost of health premiums, and I think we will continue to see that even more when the Affordable Care Act is fully implemented and is a lot less uncompensated care that all businesses have to pay for in their rates because more people will have coverage.

Mr. YARMUTH. And as a reminder when we go back to the year that this law was being debated in 2009, premiums for businesses were going up in many places as high as 38 percent. I think in California Blue Cross Blue Shield said everybody is getting a 38 percent increase. So we have seen a dramatic improvement since that time.

Mr. COHEN. That is right.

Mr. YARMUTH. Yes. Thank you very much for your testimony.

Mr. Chairman, thank you very much. I yield back.

Mr. MURPHY. The gentleman yields back.

I now go to Dr. Gingrey for 5 minutes.

Mr. GINGREY. Mr. Chairman, thank you.

Mr. Cohen, I am going to read out to you some statistics which you may or may not agree with, but a number of years ago the United States Census Bureau came out with an estimate of 47 million people, 47 million people in this country without health insurance. They got this information basically by calling and saying, do you have health insurance? Yes or no? If they had just lost their job and then off of health insurance for 1 week, the answer was no. If the call had been received 2 weeks later, the answer very well may have been yes.

So 47 million people without health insurance is one thing, but if it were for a full year without health insurance, that would be a horse of an entirely different color.

In that 47 million, let's just assume there really were 47 million people who went uninsured for a full year. Eighteen million of those people make more than $50,000 a year, 18 million of the 47 million. Ten million, it's estimated, of those 47 million are in this country illegally. Fourteen million are eligible for a safety net program, SCHIP, Medicaid, they just don't bother to fill out the paperwork or maybe they don't know, maybe they haven't been informed. But when you get right down to it there are probably no more than eight to 10 million people in this country that do not have health insurance because they are nearly poor. They are not eligible for Medicare, they are not eligible for Medicaid. So the number was so grossly inflated, and so when I hear from the other side of the aisle that we Republicans who are totally opposed to this bill, well, yes. We were, and that is one of the main reasons we were.

Now, another statistic, 1950, the average individual spent $500 a year on healthcare. In 2006, the latest year that I have statistics for, the average individual probably spent $7,000 a year for healthcare. But look at the life expectancy. The life expectancy in 1950, was the late 50s. The life expectancy in 2006, 2007, indeed, today, is 80 years old practically.

So the value, yes, health costs in this country is too high, and we need to constantly fight to lower it, find ways, eliminate waste, fraud, and abuse, anything that we can do to bring it down, but what is the value of each additional year of a person's life because of what we have done. Yes, because it is costly, but that is because of research and development, durable medical equipment, medical devices, well-trained physicians, super specialists, outstanding drugs, antibiotics six generation now because of the GAIN Act. So, of course, we were opposed to this bill. Now, look.

Let me get directly to a question for you. In 2 weeks the rules say that the signup period on the exchanges commences. Will individuals be able to sign up for a health insurance plan on October the 1st, 2013?

Mr. COHEN. Yes. Consumers will be able to sign up for a health plan on October, beginning on October 1.

Mr. GINGREY. They will actually be able to pick a plan, whether it is Cigna, Aetna, Blue Cross Blue Shield, Platinum Gold, Silver, Bronze, whatever, they will be able to do that on October the 1st?

Mr. COHEN. That is my expectation based on the progress that we have made and what I am told will be in place on October 1. Yes.

Mr. GINGREY. Thank you, and this will be my last question because I am running out of time. Most of ObamaCare is based on the premise that by forcing younger people into the market, they will help lower the costs for the older and the sicker individuals. But because the penalty is so weak, there is a real problem if all those young people don't show up, and I am afraid they won't.

In my home State of Georgia the insurance commission announced that for the average 27 year old no longer on their parents' policy, out of the basement, living on their own, premiums are set to rise anywhere from 85 to 198 percent. It seems that a $95 penalty would do little to incent young people like that to purchase coverage when faced with huge, huge premium increases.

Mr. Cohen, a lot of the premise of ObamaCare is based on getting these young people to enroll, to help broaden the pool, lower the costs for the older and sicker. Have you heard any concerns that because the penalty for ObamaCare is so weak young people may stay out of the program in the first year, and if they do opt out, what will this do to the cost for the others?

Mr. COHEN. So yes, I have read things speculating that the penalty is low and will not be a reason for people to sign up, but I think our research shows that most people want healthcare, and the barrier has been the cost, and that with subsidies care will be—the coverage will be affordable, and it will be high-quality care, and we are looking forward to people, including young people, enrolling in coverage.

Mr. MURPHY. Thank you.

Mr. GINGREY. Thank you, and Mr. Chairman, thank you for your indulgence, and I yield back.

Mr. MURPHY. Thank you, Doctor. Mr. Griffith is next, but he is going to yield his time, I mean, yield first to Mr. Shimkus to ask questions and then to Mr. Griffith.

Mr. Shimkus, you are recognized.

Mr. SHIMKUS. Thank you. I thank my colleague. I want to thank the Chairman for letting me sit in. I am not on this subcommittee, and I want to thank the Ranking Member.

Mr. Cohen, welcome. You are trying to do the job presented to you, and this is a tough committee. So let me ask a couple questions because I have been trying to get my, just like regardless of how we feel on the law, if nothing changes, and it gets enacted, members of the Congress are going to have to address our constituents' concerns and deal with that.

So what I have tried to do is a couple things. I have tried to meet with my grantees. I have met with one, but some are now making themselves available to me, and I am just trying to do it to get information. So I don't know what we can do from the Administration's perspective to encourage the grantees to talk to the elected members of Congress and the regions that they are going to represent, but I would personally appreciate it because I am trying to develop a relationship because constituents are going to come to us. They do for Medicare, they come to us for Medicaid, they do for So-

cial Security, veterans affairs. That is part of our job, and I just need help.

So I just say that as a member appealing to the Administration.

Mr. COHEN. So I think we would like to work with you on a process for getting you the information that you want, and are entitled to that won't be disruptive of the work that needs to be happening, particularly at this particularly critical moment when they are just getting ready to start their work.

Mr. SHIMKUS. Yes, and I get it, I mean, because I did meet with one, and it was very helpful.

The other request I have is we have asked if we can get, especially our staff member who deals, most of us have constituent service people in our Congressional districts. I have one that she is an expert now on Medicare and Medicaid. I have another one who is an expert on veterans' affairs. We have put forth a request to say can't I get this person trained? Can they sit through the training?

Mr. COHEN. Yes.

Mr. SHIMKUS. We were told no. So——

Mr. COHEN. You were told no by?

Mr. SHIMKUS. I can get you the answers, but we were told we can't, they wouldn't allow us to be trained. So——

Mr. COHEN. That doesn't sound right to me.

Mr. SHIMKUS. That is fine. I want my staffer to know as much information as they can as they are going to have to deal with this. Hopefully not but——

Mr. COHEN. No. Absolutely.

Mr. SHIMKUS [continuing]. My guess is they might have to deal with this. So when I talked to the one grantee, this is the point that they made. They have got 33 Navigators, they are dispersed throughout healthcare. We have kind of vetted that out in this hearing today.

But they only have two slots for training. There is a 20-hour, I mean, there is an online training. I have learned that much, and then I am from Illinois, so there is a 2-day training, probably an overnight, and that is kind of where we were researching to get our staffer involved in both those trainings, but the real——

Mr. COHEN. At the state-required training or is that——

Mr. SHIMKUS. Yes. That is why I am trying to figure it out. So but my point is this one grantee will before the operational date of October 1, will only be able to get two of his individuals through the training. I am just—and I can tell you, I don't want to air, but I would be glad to talk to you.

Mr. COHEN. If our legislative folks could get in touch with your staff——

Mr. SHIMKUS. Thank you.

Mr. COHEN [continuing]. I would really be very happy to look into that in particular.

Mr. SHIMKUS. And then they also raised the issue that getting a clearance for these people is basically the State of Illinois providing clearance. They will not be ready to handle this information because of the clearance process. So I am just using this opportunity to show you some of the concerns that I have, and I am very concerned because I want to, I don't like the law, I voted against

the law, but I know I am going to get calls about how we can help my constituents, and I want to be ready to do that.

Mr. COHEN. So I appreciate that very much. I have to say that I am concerned that some states have put in requirements which they are entitled to do, you know, but that are making it a little bit more difficult for the Navigators to get ready in time for October 1. So maybe we can work with you and try to work through some of those issues.

Mr. SHIMKUS. I would appreciate it. Let me just go the final question. It was kind of based upon listening to your testimony today about, you know, whether you are going to go door to door, and I don't have a dog in that fight, but I am concerned that as we have people who are trained and qualified that we have a process that someone can go back to a government Web site and say, they are legit, they are not legit. Have you all considered putting a list of names of the Navigators on a .gov site or something?

Mr. COHEN. So we are working through that. I think the latest discussion is that we will provide the list to the state insurance departments so that there will be a local place where people can go to make sure that folks are who they are supposed to be.

Mr. SHIMKUS. And it is up to them if they put it online or not?

Mr. COHEN. Right.

Mr. SHIMKUS. OK. Again, Chairman, thank you very much. Ranking Member, thank you very much, and I yield back the time.

Mr. MURPHY. I thank the gentleman from Illinois, and I know, I think many offices would love to know how our staff can also log on to get the training as well. Thank you.

Finally, Mr. Griffith is recognized for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman. I appreciate that very much.

Let me follow up on that. It might also be good to get some of these folks' IDs. In this morning's "Bluefield Daily Telegraph" there is an article about door-to-door scammers looking for prescription drug information. I know you can't stop all the bad actors out there, but we have a group running around in Tazewell County, Virginia, pretending to be part of the Appalachian Agency for Senior Citizens, and even though you are telling folks they are not supposed to do door to door, the word out there is is that some people are going to do door to door.

I would now draw your attention to Exhibit 2, and you will notice in that proposal in the second paragraph it says that they propose going door to door. So even some of the proposals and some of the people who are supposed to be doing this apparently have the misunderstanding they are supposed to go door to door.

One of the other questions that I have for you and then I will come back to Exhibit 2 so you might want to leave that open is that the State Corporation Commission in Virginia, Bureau of Insurance approved or certified as acceptable plans at the end of July. It was their assumption that they would have some information by now. They as of this morning do not know whether or not their plans, because Virginia is not doing its own exchange, it is going through federal exchange, but the State Bureau of Insurance was sending plans that were approved. They haven't heard any-

thing back as of this morning, so they don't know whether these plans are actually going to be approved or not.

And so I would ask you to check on that, please, and get us some help because we have got 7 business days left to go, and the State of Virginia doesn't know what plans are going to be approved by the——

Mr. COHEN. I absolutely will. That surprises me because I know we have been in contact with the states on a regular basis, but I will absolutely follow through on that.

Mr. GRIFFITH. And I will just tell you we checked with him this morning. I will tell you another concern is and this happens in a lot of rural areas I am sure, is that there is not going to be competition in ten of the jurisdictions I represent. There is either only one shop plan or only one individual plan, and five of those jurisdictions, the counties of Buchanan, Grayson, Lee, Scott, and the city of Bristol, there is only one shop plan and one individual plan. And so a lot of my constituents do not have a whole lot of choices to choose from, and obviously if there is a monopoly, that may have affect prices as well, wouldn't you think?

That being said I will point you back now to the Exhibit 2. Just so you will know that we are looking at this, you will see on the first page the project abstract for the Navigator, and it is going to cover two counties, one in Florida, one in Texas. On the next page you will see further that the application says they will have 50 exchange Navigators, and then you have to follow through, and we have done some of the math for you, and my time is running out, so I will lead you through some of this and then ask you to comment.

On the next page you will see their enrollment goals, and they state in the second bullet point that they want enrollment goals about 75 percent of those they are trying to reach, and they indicate that through provision of literature, et cetera, a total of 288,750 per targeted county by the end of the program year or a total of 577,700, and so what we have got is we have got a Navigator in their statement saying that somebody in your office approved that they are going to enroll 577,000 people plus by the end of the year, and that works out to 11,500 enrollees per Navigator when you take that 577,500 people and divide it by 50 Navigators. And, of course, remember these are the folks who were also not only going to be doing fairs and so forth but were going to be saying they were going to go door to door.

Do you really believe that one Navigator can enroll 11,500 people, taking the time that they had originally when this was done until the end of the year? It looks like it is 31 people a day counting weekends and holidays. That is not really very realistic, is it? I have done door knocking before, and I have done a lot of voter outreach, and to reach that many people a day and actually get them to say yes is not an easy accomplishment.

Mr. COHEN. So I would say again, I mean, this is clearly a proposal, an application. It was approved. This grantee was approved. They got a grant. There is a budget process that happens as part of that approval. I don't, I can't tell you. I will commit to you to find out more information about this grantee if you would like, but I can't tell you whether this is how it ended up or whether there

were any changes, and I don't feel comfortable commenting on it because I literally have, am just seeing it now. So——

Mr. GRIFFITH. I understand it if you could give me some comment later, I would appreciate that very much. These are concerning numbers, and obviously there are some people out there at least thinking they are supposed to go door to door, and that is of concern because then when people start going door to door it makes it much——

Mr. COHEN. Right.

Mr. GRIFFITH [continuing]. Easier for particularly senior citizens to be victims of bad actors and not the real Navigators. They are not going to ascribe that to the real Navigators but folks going out there and they know people are supposed to be going door to door, people are coming by, and the next thing you know they are finding out whether or not they have prescription drugs, and then what they are doing apparently in that particular county or what the sheriff fears is that they will go back and rob the house, and they are more interested in getting the drugs than they are getting TVs, and they are just trying to figure out which are the prime targets. And so that is of concern.

I will also tell you and I am not sure that this falls under your jurisdiction, but we are having a real problem with the doctor shortage in the Commonwealth of Virginia. There is an article today about some people in the eastern part of the state that are having a problem. I don't represent that particular part of Virginia, and I will tell you that recently one of my hospitals closed. Their number one reason was ObamaCare, and the aspects, the cuts to Medicare, the double, I call it the scissor where the states under the original plan were supposed to but didn't have to on the Supreme Court ruling, expand Medicaid and then the final straw for those particular folks besides the war on coal which lowered the economy in the area so you had less insured people, the final straw was the fact that they couldn't get doctors to staff the hospital in an adequate fashion and so now I have got folks that are going to have to travel an hour to an hour and a half to get cardiac care. It is a very serious concern. I am very worried about the people who live in my district and whether or not they are going to be able to get adequate healthcare under this ObamaCare Program.

And like the others who have spoken, I, too, hope that you will educate us on how to enroll people, because we will get calls.

Mr. MURPHY. OK. The gentleman's time has expired, and with that, Mr. Cohen, we appreciate you coming for this committee again today, and I ask unanimous consent that the written opening statements of other members be introduced into the record if they wish, and without objection those will be entered into the record.

I also ask unanimous consent to enter the document binder into the record subject to appropriate redactions by staff. I also ask for unanimous consent to put an article into the record from the "Business Journal" dated September 12, 2013.

So without objection that is so ordered. *

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*The information has been retained in committee files and is also available at *http://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=101323*

Mr. MURPHY. Again, Mr. Cohen, thank you so much for coming. We appreciate your timely response also to members' requests for assistance for their staff and others in providing information and for the testimony that you and other members have asked here and the devotion of members at this hearing today.

The committee rules provide that members have 10 days to submit additional questions for the record of the witness. And with that this hearing is now adjourned.

Mr. COHEN. Thank you.

[Whereupon, at 12:26 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

OPENING STATEMENT OF THE HON. FRED UPTON

We are now less than two weeks away from when the health law's enrollment officially kicks off. It has been a rocky three and a half years to date.

Unfortunately, the law's implementation has been plagued by confusion, uncertainty, delays, and missed deadlines. The broken promises have reached near epidemic proportions. Hardly a day goes by without workers losing the coverage the president promised they could keep, or new figures detailing the looming rate shock in store for millions of Americans. The president's hometown Chicago Tribune lamented about the part-timing of America, and many businesses have frozen hiring altogether to avoid the law's costly mandates.

Since health care reform was signed into law, two programs closed prematurely because they ran out of money: the Pre-Existing Condition Insurance Plan and the Early Retiree Reinsurance Program. The CLASS Act was repealed. Fundamental requirements of the law, like the employer mandate, were delayed with little fanfare, and hundreds of waivers were handed out to health plans that could not meet the requirements of the law.

In the last few weeks, even more of the law's consequences for American families have come to light. Some employers have announced that they will no longer cover spouses and children. Others have decided that they will need to jettison their retirees from company health care plans to the exchanges.

The American people deserve better than this. They deserve better than a law that was crafted behind closed doors and rammed through despite wide opposition. Although there was no oversight of the law until Republicans regained control of the House in 2011, some have still questioned why this committee has investigated and conducted extensive hearings on the implementation of the Affordable Care Act. I believe it is our duty to ask questions and get the facts about how programs are going to work, and what they will mean for the American people, rather than sit back and wait until it is too late to ask questions after taxpayer dollars have been squandered.

Mr. Gary Cohen, the Director of the Center for Consumer Information and Insurance Oversight, has appeared before this committee before and is here today to explain what we can expect when enrollment begins in less than two weeks. In April, Mr. Cohen testified that everything was "on track"—but "on track" to what? Just weeks after his testimony, the administration delayed the employer mandate and rolled back the verification process, opening us up for potentially billions of dollars in fraud. With less than two weeks until launch, it is time for the administration to be frank with the American people. When will CCIIO finalize and announce the approved insurance plans and premium costs? Will states be ready? Will people who like their insurance plans be able to keep them? I hope Mr. Cohen will be able to offer specific answers to these questions today rather than vague assurances that everything is on track.

# # #

From the The Business Journal :http://www.bizjournals.com/triad/blog/2013/09/randolph-hospital-dismisses-flap-over.html

Sep 12, 2013, 9:00am EDT Updated: Sep 12, 2013, 10:38am EDT

Randolph Hospital dismisses flap over navigator grant letter from Congress

Owen Covington
Reporter- *The Business Journal*
Email | Twitter | Google+ | LinkedIn

I recently reported that **Randolph Hospital** was one of four groups in the state and among more than 100 in the country that received grants to help educate the public about the health insurance exchanges set to open Oct. 1.

The hospital is using the $350,000 grant to create a team of five navigators who will begin education efforts in Randolph, Moore and Montgomery counties in the coming weeks. The team will target those currently without health insurance and help them understand how to purchase coverage through the new exchange.

But as is the case with nearly anything and everything associated with the Affordable Care Act, this round of $67 million in federal grants became coated in political rhetoric after the recipients received extra attention from a group of Republican members of Congress late last month.

What kicked it off was a letter from 15 members of the House Committee on Energy and Commerce to about half of the grant recipients, including Randolph Hospital, requesting more information about how they plan to use the money.

The Aug. 29 letter, signed by the committee chairman and members including U.S. Rep. Renee Ellmers, an N.C. Republican from Dunn, sparked protests from a number of grant recipients as well as the Obama administration, which described the letter as a "blatant and shameful attempt to intimidate," according to Kaiser Health News.

The letter asked recipients to brief the committee on their proposal and provide extensive information about their plans. Some objected that the request would make it difficult for the navigator programs to get up an running before Oct. 1 and would have a chilling effect on hiring and training workers.

"Was this an attempt by members of the committee to basically stop and slow down the navigator process?" Lisa Hamler-Fugitt, executive director of the **Ohio Association of Foodbanks**, a grant recipient, said to Kaiser Health News. "We're going to stop now and pull together voluminous documents to provide back to the committee?

I reached out to Randolph Hospital and found that administrators with the Asheboro hospital didn't share the same opinion about the intent of the letter, or its impact.

"From my perspective, and the hospital's perspective, we just see this as they're doing their due diligence and making sure the organizations that are receiving these funds are going to be using the funds in the manner in which they were intended," said Devin Griffith, vice president of care continuum and support services at Randolph. "We don't foresee it being a problem."

Griffith said the hospital has already briefed the committee staff during a 50-minute conference call and had no trouble pulling together the requested information, most of which he said was included in its original application.

The letter requested documentation explaining the work that will be performed and the organization that will perform it, as well as information about how the staff will be trained, the policies used to monitor staff and how the organization will use the information it gathers.

Additionally, recipients are to provide information about whether they have been contacted by health insurers or health care companies about the grant and documentation of all communications related to the grant.

Griffith noted that as a health care provider, Randolph Hospital already has many of the policies and procedures in place for screening job applicants — and also protecting confidential information —that other grant recipients might not be quite as familiar with.

As far as being prepared in time, Griffith anticipates having the full navigator team trained and in place by Sept. 23 to start the yearlong effort.

"We don't see this as a burden," Griffith said.

> Owen Covington covers health care, insurance, law/bankruptcy court, media/advertising, local government and sports business.

THE COMMITTEE ON ENERGY AND COMMERCE

Memorandum

September 17, 2013

To: Members, Subcommittee on Oversight and Investigations

From: Majority Committee Staff

Subject: Hearing entitled "Two Weeks Until Enrollment: Questions for CCIIO"

On Thursday, September 19, 2013, at 10:00 a.m. in room 2123 of the Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing examining the impending start of enrollment for the Patient Protection and Affordable Care Act (PPACA).

I. Witness

Mr. Gary Cohen
Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

II. Background

The Center for Consumer Information and Insurance Oversight (CCIIO) is the government agency responsible for the implementation of the provisions related to private health insurance in the PPACA. The Subcommittee on Oversight and Investigations has previously held hearings on the work of CCIIO on February 16 and April 1, 2011, March 21, 2012, and April 24, 2013.

CCIIO defines its current areas of emphasis as:[1]

- Ensuring compliance with the new market rules in the PPACA.
- Helping States review insurance rate increases and overseeing new Medical Loss Ratio rules.

[1] Cciio.cms.gov/index.html.

- Providing oversight for the State health insurance exchanges and compiling data for healthcare.gov.
- Administering the Consumer Assistance Program, Pre-Existing Condition Insurance Plan, and Early Retiree Reinsurance Program.

CCIIO is responsible for a number of programs that have been created since the passage of the PPACA. Most notably, CCIIO was responsible for the program that administered waivers to the PPACA's prohibition on annual or lifetime limits in insurance plans.[2] These waivers were granted to prevent millions from facing either drastic premium increases or the loss of coverage as a result of PPACA. The Committee previously examined CCIIO's implementation and administration of two other programs: the Pre-Existing Condition Insurance Plan (PCIP) and the Early Retiree Reinsurance Program (ERRP). The Obama Administration suspended new PCIP enrollments effective February 16, 2013, due to concerns over financial constraints. Similarly, the ERRP, which was intended to last until 2014, also depleted its funding too rapidly and halted payments for claims incurred after December 31, 2011. Last month, CCIIO awarded $67 million in grants to a variety of organizations to act as Navigators under the PPACA. These Navigators will provide assistance in enrolling individuals in qualified health plans, and the Committee has requested information from a sampling of these groups concerning how they will be utilizing taxpayer dollars.

CCIIO is the lead agency in the establishment of the health insurance marketplaces (Exchanges) that will begin enrollment in October 2013. To date, 18 States have been approved to operate their own Exchanges, and an additional 7 States are approved to operate an Exchange in partnership with the Department of Health and Human Services (HHS).[3] At its hearing on April 18, Secretary Sebelius informed the Subcommittee on Health that the Exchanges will be ready this fall, but also noted that there is no contingency plan in place if that goal is not achieved.[4] Meanwhile, while contractors responsible for building the exchange enrollment and verifications systems told the Subcommittee on Health last week that they were on time, an independent expert testified that the law could have a "rocky" start.[5]

Finally, CCIIO is responsible for the many other changes made by the PPACA to the private health insurance market, including coverage for young adults, grandfathered plans, the new requirements for Medical Loss Ratios, and the review of insurance rate increases.

III. Issues

The following issues will be examined at the hearing:

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[2] http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html.
[3] http://cciio.cms.gov/resources/factsheets/state-marketplaces.html.
[4] http://energycommerce.house.gov/hearing/financial-review-department-health-and-human-services-and-its-fy-2014-budget.
[5] David Morgan, *Obamacare exchanges seen headed for 'rocky' enrollment state: expert*, Reuters, Sept. 10, 2013.

- Are there any issues or problems Congress should be aware of with enrollment set to begin in less than 2 weeks?

- Will the Exchanges, either those being operated by States, those run in partnership with HHS, or the Federal Exchanges, be fully operational by January 1, 2014?

- What has been the CCIIO experience in handling the numerous new requirements of the PPACA as the country readies itself for full implementation of the law in 2014?

IV. Staff Contacts

If you have any questions regarding the hearing, please contact Sean Hayes at (202) 225-2927.

November 8, 2013

Mr. Gary Cohen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Cohen:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, September 19, 2013, to testify at the hearing entitled "Two Weeks Until Enrollment: Questions for CCIIO."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests by the close of business on Friday, November 22, 2013. Your responses should be e-mailed to the Legislative Clerk in Word format at brittany.havens@mail.house.gov and mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Gary Cohen's Hearing
"Two Weeks Until Enrollment: Questions for CCIIO"
Before
Energy & Commerce Committee
Oversight & Investigations Subcommittee

September 19, 2013

Attachment 1—Additional Questions for the Record

The Honorable Marsha Blackburn

1. **I'm very concerned about reports we've seen that the Labor Department is issuing additional regulations to target self-insured plans. What communication do you have with them or within your own agency about this? And furthermore, what data do you have that suggests more regulation is needed?**

Answer: While CMS regularly confers with the Department of Labor on a variety of issues, I am not familiar with the reports to which you refer. The Department of Labor is the primary regulator of self-insured plans, and questions related to that topic are best directed to that Department.

The Honorable G.K. Butterfield

1. **Mr. Cohen, one of the biggest benefits in the Affordable Care Act was the expansion of Medicaid. After the Supreme Court ruled on the law, states were given the option to expand the Medicaid program to millions of Americans. They were not required to do so – but since the expansion was such a good deal for states, paid for almost entirely with federal funds – it was inconceivable that states would turn down this opportunity to provide health insurance for their low-income residents.**

   But Mr. Cohen, my governor in North Carolina turned down this opportunity. This is particularly frustrating for me, because many of my constituents would have benefited if the state had chosen to accept federal funds. Currently in North Carolina alone, there are 720,000 uninsured adults that would have benefited from Medicaid if the state had accepted federal funds to expand their Medicaid program – including many thousands of my constituents.

   Mr. Cohen, what do you think about this decision by my governor, and other states that have turned down the Medicaid expansion? What are your thoughts on the advantages of Medicaid expansion?

   I fail to comprehend why a governor would choose to leave so many low-income people without insurance. And yet, more than 20 states including North Carolina appear to be declining the Medicaid expansion.

Answer: CMS agrees that expanding Medicaid has financial and social benefits for states, with the Federal Government covering 100 percent of the cost of covering Medicaid for newly eligible low-income adults under age 65 for the first three years and no less than 90 percent in following years. This expanded coverage would dramatically reduce uncompensated care in emergency rooms and other care settings, lowering the financial burden on hospitals, providers, employers, and patients.

CMS continues to work with states on Medicaid-expansion implementation. There is no deadline by which a state must notify the Federal Government of its intent to expand its Medicaid program, and states may choose to expand Medicaid at any time. However, while states have flexibility regarding how they implement the Medicaid expansion, Federal match rates for medical assistance for newly eligible individuals are statutorily tied to specific calendar years: states will receive 100 percent support for the newly eligible adults in 2014, 2015, and 2016; 95 percent in 2017, 94 percent in 2018, 93 percent in 2019; and 90 percent in 2020 and future years, remaining level thereafter.

2. **Mr. Cohen, one in four of my constituents are at or below the federal poverty level and 137,000 currently lack health insurance. Many of my constituents will benefit from premium tax credits under ACA to help reduce the cost of health insurance premiums. In fact, the Congressional Budget Office projects 8 in 10 people will benefit from these credits and a recent RAND report said the average Marketplace consumer will reduce their premium by 35 percent.**

   If I am a single male from Edenton, North Carolina, and I make $47,000, which is less that 400% of the federal poverty level, then I qualify for tax credits to help cover my insurance cost. Can you explain how those tax credits will benefit my constituents up front when they enroll in the Marketplace?

Answer: In general, under the Affordable Care Act, qualified individuals with incomes between 100 and 400 percent FPL, who are not eligible for certain health insurance coverage through their employer, Medicaid, Medicare, or certain other types of coverage, and who purchase insurance coverage through the Marketplaces, are eligible for tax credits to reduce the cost of coverage. The amount of the tax credit is based on a benchmark premium: the premium for the second-lowest-cost silver plan (a plan that provides EHBs and has an actuarial value of 70 percent) available in the Marketplace where the individual is eligible to purchase coverage. The amount of the tax credit also varies with the individual's income, such that the premium for the benchmark plan for an individual earning 100-133 percent FPL would be capped at 2 percent of the individual's household income. CMS expects that these tax credits, coupled with the Affordable Care Act's insurance market reforms, will enable access to affordable, comprehensive insurance without discrimination based on gender or pre-existing conditions.

A recent report found that of the estimated 21.9 million uninsured Americans eligible to purchase coverage in the Marketplace, 6.4 million may be able to pay $100 or less per person per month for the second lowest-cost silver plan in the Marketplace in their state in 2014, after taking into account their available premium tax credits. An additional 4.3 million may be able to pay $100 or less per person per month by using their premium tax credit to purchase the lowest-cost bronze plan available to them.[1]

[1] http://aspe.hhs.gov/health/reports/2013/Uninsured/ib_uninsured.cfm

3. **With continuous attacks on the ACA from detractors, we have not made it easy to get the word out about the many benefits of the health care law. Navigators and people in the community are critical to education those who can benefit most from the law. This afternoon I am hosting an event on how faith communities can help educate people about the ACA.**

   Can you discuss some of the important outreach and support efforts Navigators are providing in disadvantages communities like those in eastern North Carolina? How can community groups, like the faith community, become more involved in educating the uninsured about the Marketplaces?

Answer: In July, CMS finalized a rule outlining the standards for Navigators, in-person assisters, and certified application counselors in the Federally-facilitated and State Partnership Marketplace. Navigators are trained to provide accurate and impartial assistance to consumers shopping for coverage in the new Marketplace, including consumers who are not familiar with health insurance, have limited English proficiency, or are living with a disability.

Consumers can get assistance enrolling in the Marketplace in a number of different ways, including through trained navigators, in-person assistance personnel, or through certified application counselors. The navigator, in-person assister, and certified application counselor programs are critical tools to provide consumers with in-person help. Each assister undergoes a rigorous training process, including privacy training, and is tested to ensure they're prepared to help people enroll in the Marketplace. Thousands of enrollment assisters have been trained by CMS. In addition, community health centers are also playing a crucial role in the enrollment process. There are trained enrollment assisters at nearly every community health center in the country.

In North Carolina, one such assister organization is the North Carolina Community Care Networks. North Carolina Community Care Networks, Inc. are consortia that total more than 100 organizations who will work to inform consumers statewide, with particular focus in areas where there is a higher concentration of uninsured. These networks will be serving to reach out, inform, educate and help enroll North Carolinians, and include organizations in the legal rights, faith-based, agricultural, and aging communities.

For community groups that are interested in becoming more involved in educating people about their coverage options, CMS has official resources available at www.marketplace.cms.gov, including training to become a Certified Application Counselor (CAC), FAQs about eligibility and enrollment, and Census information and research to help target the uninsured.

4. **Mr. Cohen, on August 29th, fifteen Members of this committee requested detailed documents and briefings from the 51 organizations approved as Navigators. I recognize that in July CMS finalized a rule which set standards for Navigators and established robust and demanding criteria for approval.**

   Can you walk us through some of the stringent standards including the strict privacy and security standards the Navigators must meet in order to be approved?

   Would you say that the review demanded by some on this committee was duplicative and unnecessary after the thorough process of evaluating Navigators at CMS?

Do you believe the duplicative and unnecessary efforts from some of the members of this committee obstructed the ability of Navigators to move forward with their obligations to help people access affordable health care?

Answer: To be eligible to receive a Navigator grant, as required in the Affordable Care Act, an applicant had to demonstrate that it had existing relationships or could readily establish relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan. In addition to the rules set forth in the law, funding announcement, and regulations, like other entities and individuals seeking to conduct business with the Federal Government, recipients of Navigator grants were subjected to a robust screening process before the grants were awarded.[2] Awardees must also meet any licensing, certification, or other standards prescribed by the state or Marketplace, if applicable, so long as these state Navigator standards do not prevent the application of Title I of the Affordable Care Act. Fourteen states with Federally-facilitated Marketplaces have set additional requirements for Navigators.[3]

These groups are trying to do the same type of work they have done in their communities for years and in some cases, decades, and it's unfortunate that they are the subject of inquiries that suggest they are doing something wrong by helping people in their communities enroll in health care coverage. This type of scrutiny risks creating an insinuation that well-respected organizations and institutions--like food banks, large state universities and United Way chapters--have somehow done something inappropriate--before they've spoken to a single consumer. It is disappointing that their resources and attention have been diverted at this critical time.

5. **In a few weeks, it will be easier than ever before for North Carolinians and all Americans to shop for health insurance. Consumers will be able to go online, fill out a streamlined application, and sign up for health care coverage all in one sitting. And they will no longer be disqualified due to preexisting conditions or other arbitrary criteria.**

   Can you explain options for consumers with additional questions, including accessing the toll-free call center or meeting face to face with a Navigator?

Answer: Educating consumers and businesses about the benefits that Marketplaces have to offer is the first step toward helping them take advantage of those benefits. We know quite a bit about the uninsured Americans we need to reach—many have never had health insurance, so the transaction of selecting, applying, and enrolling in health coverage will be unfamiliar to them. According to a CMS analysis of the 2011 American Community Survey, 20 percent of uninsured adults have not completed high school. To effectively reach these populations about their new health insurance options,

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[2] Entities and individuals are not eligible for a Federal grant, including a Navigator grant, if they are on the Excluded Parties List of entities or individuals who have been suspended or debarred by any Federal agency. Suspensions from receiving Federal grant money of up to one year may be issued based on indictments, information, or adequate evidence involving environmental crimes, contract fraud, embezzlement, theft, forgery, bribery, poor performance, non-performance, or false statements. Debarments from receiving Federal grant money for a longer period of time may be issued based on convictions, civil judgment or fact-based cases involving environmental crimes, contract fraud, embezzlement, theft, forgery, bribery, poor performance, non-performance, or false statements, as well as other causes. This careful screening will help to ensure that individuals or organizations that pose a risk to the Federal Government are not awarded Federal Navigator grants.

[3] The states are Arkansas, Florida, Georgia, Indiana, Iowa, Louisiana, Maine, Montana, Nebraska, Ohio, Tennessee, Texas, Virginia, and Wisconsin. See http://www.commonwealthfund.org/Blog/2013/Jul/Will-State-Laws-Hinder-Federal-Marketplaces-Outreach.aspx.

information should be provided in multiple ways, including by trusted people connected to the community in an appropriate manner.

Consumers who have additional questions regarding the application process for the Health Insurance Marketplace will be able to contact our toll-free call center, which is open 24 hours a day and can be reached at 1-800-318-2596. The toll-free call center can respond to requests in 150 languages. Additionally, consumers can use the Find Local Help tool on Healthcare.gov[4] to find a Navigator or other similar in-person assisters in their area who can offer additional help in applying for coverage.

[4] Available at https://localhelp.healthcare.gov/

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

1. **When did HHS make the decision to increase funding for the Navigator Program?**

Answer: HHS announced additional funding on August 15, 2013.

2. **Would states like California, who have their own marketplace and its own Navigator Program and are operating under the rules of the Federal Government, be under the same guidance, rules or regulations as an insurance agent?**

Answer: Agents and brokers in all states, including SBM states, are licensed by the state's department of insurance. There are very specific state laws governing the practices, training requirements and continuing education requirements for agents and brokers. The State-based Marketplaces are training agents and brokers about how to use their Marketplace websites and what the Affordable Care Act requirements are, etc., and registering those that have taken their training and passed the exam so they can sell through the Marketplace.

The Affordable Care Act requires Marketplaces to establish a Navigator program to help consumers understand new coverage options and find the most affordable coverage that meets their health care needs. HHS wrote the regulations creating conflict of interest, training, certification, and recertification, and meaningful access standards for Navigators in the Federally-facilitated and State Partnership Marketplaces, and to non-Navigator assistance personnel in State Exchanges that are funded through Federal Exchange Establishment grants. Navigator responsibilities are defined by the Federal regulations, which can be supplemented by state law or the departments of insurance as long as those state requirements do not prevent the application of Title I of the Affordable Care Act. The states have entered into grant arrangements with Navigator entities, are funding them through various non-Federal funding streams (state appropriations, private foundation grants, etc.) during this first year, and have developed training programs and certification requirements consistent with Federal law and regulations, but separate from the licensing requirements for agents and brokers. CMS regulations specifically prohibit Navigators from serving as agents and brokers; Navigators are subject to different conflict of interest requirements and Navigators are prohibited from receiving compensation from issuers in connection with enrolling consumers in coverage.

3. **Please provide us with the information regarding which states require criminal background checks and which ones do not.**

Answer: Consumers can get assistance enrolling in the Marketplace in a number of different ways, including through assisters such as trained navigators, in-person assistance personnel, or through certified application counselors. We understand that thirteen State-based Marketplaces perform some type of background checks on Navigators and/or the other types of assisters listed above: California, Colorado, Connecticut, the District of Columbia, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Oregon, Rhode Island, Vermont, and Washington have and will continue to perform background

checks on Navigators and assisters. In terms of the Federally-facilitated Marketplace, we understand that Arkansas and Iowa will apply background checks to Navigators, and Illinois, Georgia, Florida, Indiana, Montana, Ohio, Tennessee, Utah, and Wisconsin will apply background checks to Navigators and the other types of assisters listed above.

4. **How can our staff get the appropriate training to be able to answer questions and help our constituents?**

Answer: CMS training materials and presentations are publicly available at http://marketplace.cms.gov/training/get-training.html. CMS is happy to work with your staff to ensure you have the necessary information to help your constituents find and enroll in health coverage.

The Honorable Steve Scalise

1. **Please provide the name of any Navigator entity that has dropped out of the Program due to scrutiny.**

Answer: Several Navigator grantees chose to terminate their grant after grants were awarded in mid-August. In particular, Cardon Healthcare and West Virginia Parent, Training, and Information, Inc., indicated that heightened scrutiny of the Navigator Program factored into part of the reasons for rescinding their grant. An additional grantee, Children's Hospital Medical Center (OH), cited additional restrictions placed by the state legislature as a barrier to their participation in the grant program.

The Honorable Gregg Harper

1. **Can you please describe the budget review process for the grant applicants and whether or not it included additional payment for each enrollee that they sign up?**

Answer: A budget review is the process of reviewing the line-item (object class) budget (and accompanying budget justification/narrative) submitted as part of a grant application, including Federal funds requested and any required matching or cost sharing, in order to identify unallowable costs and anomalies, ensure proper categorization of costs, verify rates, and check arithmetic accuracy.

Navigators are required to perform a number of activities including education and enrollment assistance. As part of the grant application process, each Navigator grantee organization had to submit a budget and detail how they intended to achieve the scope of work of the grant award. While some of the successful Navigator applicants proposed paying per-enrollee in their applications, those organizations agreed to forgo that system during the post-award budget negotiations. Through the Navigator's execution of the cooperative agreement, the Navigators must follow that agreement irrespective of what they included in their proposed budget.

As part of the standard Federal grant management process, we looked at the applications' budgetary narratives and conducted cost analyses to determine if the estimated costs for items like employee salaries, supplies, travel, etc. are allowable and reasonable. Additionally, through our post-award monitoring, we can ensure that the actual costs the grant recipients incur for items like employee salaries are allowable and reasonable. We followed the standard cost analysis process that is used

throughout HHS and the Federal Government to ensure that the awardees' costs are allowable and reasonable. There is no additional payment made to Federally-facilitated Marketplace Navigator grantees for enrolling individuals in coverage offered through the Marketplaces. However, State-based Marketplaces, which run their own assister and Navigator programs, may pay-per-enrollee.

2. Which states are paying some portion of compensation for each enrollee that they sign up? What additional amounts are they being paid per enrollee?

Answer: There are a few states conducting pay by enrollment; California is an example.

In California, the payment is going to the organization, not to the individual enrollment assisters. The organizations will then pay the individual assisters based on whatever contract they have with them.

Some Marketplaces are holding back a percentage of their funds (10-20 percent) to use as bonus funds, in essence, for those entities whose assisters have enrolled the most individuals/families/businesses in plans.

3. Are any state Navigator programs going door to door? If so, which ones?

Answer: Navigator grantees have been instructed that they should not be going door-to-door to provide assistance with enrollment; however, they may choose to go door-to-door to conduct outreach and education activities such as passing out flyers.

4. Is it HHS' position that Navigators can use money awarded to them in the grant to make robo calls?

Answer: Navigator grantees should not be making robocalls. If a grantee proposed to undertake such activities in their original application, CMS grant project officers would work with grantees to help them understand that this activity should not be conducted.

The Honorable Pete Olson

1. How many Navigator entities are there? Of those entities, how many have hired people for the Navigator position or currently have people in place to be Navigators to fulfill these requirements?

Answer: There are currently 102 Navigator grantees. Each grantee has either current staff or new staff hired to perform Navigator activities. Most grantees have Navigators working on the ground; however, a few grantees are still going through either the Federal training or state requirements before beginning their work as a Navigator.

The Honorable Morgan Griffith

1. Do you believe that one Navigator can enroll 11,500 people, which averages out to 31 people per day?

Answer: Sometimes applicants overestimate the number of people they will realistically be able to reach. However, an unrealistic estimate did not, of itself, eliminate an applicant from consideration. Applications are not scored based solely on the number of consumers the applicant indicated that they would serve in their project abstract. Applicants generally submit well-thought-out project plans. Applicants are approved to receive a Federal Navigator grant based on their project narrative explaining how they will implement their proposal in accordance with their proposed budget. Grant project officers work with all grantees to discuss issues within their application, including estimates of consumers potentially served that are not realistic.

The Honorable John Dingell

1. **Please explain why in 2012, insurers were less likely than in previous years to request rate increases of 10 percent or more.**

Answer: I believe increased transparency has helped to reduce the number of rate increases of 10 percent or more. Under the Affordable Care Act, insurance companies are now required to justify a rate increase of 10 percent or more, shedding light on arbitrary or unnecessary costs. Since this rule was implemented,[5] the number of requests for insurance premium increases of 10 percent or more have plummeted from 75 percent in 2010[6] to 43 percent in 2011 to 26 percent in 2012 and an estimated 14 percent in the first quarter of 2013[7], and Americans have saved an estimated $1.2 billion on their health insurance premiums, thanks to review of all rate increase requests.[8]

2. **Please elaborate on your expectation that the consumers will have more and better information because of the structure of the marketplaces.**

Answer: Answer: Consumers will be able to select an insurance plan with confidence that it will cover key health care services when they need them. All non-grandfathered policies in the individual and small group markets will cover essential health benefits, which include items and services in ten statutory benefit categories.[9] Additionally, non-grandfathered health plans in the individual and small group markets will provide coverage in one of several standardized tiers. These tiers will allow consumers to compare plans with similar levels of coverage, which, along with comparing premiums, provider networks, and other factors, will help consumers make more informed decisions.

3. **Please submit additional information on why in the 16 states for which we have data, our preliminary rates for health insurance in the marketplaces, 19 percent are less expensive than predicted.**

Answer: We are already seeing evidence that the Marketplace is encouraging plans to compete for consumers, resulting in affordable rates. In the sixteen states[10] for which data are available, the preliminary rate for the lowest-cost silver plan in the individual market in 2014 is, on average,

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[5] Health Insurance Rate Review – Final Rule on Rate Increase Disclosure and Review: http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf

[6] http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review09112012a.html

[7] http://aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.cfm

[8] http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.cfm

[9] Essential Health Benefits: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm

[10] The states are: California, Colorado, Connecticut, District of Columbia, Maine , Maryland , Nevada, New Mexico, New York, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Virginia, and Washington.

19 percent less expensive than the estimate based on projections by the Congressional Budget Office (CBO).[11] Outside analysts have reached similar conclusions. A recent Kaiser Family Foundation report found that "while premiums will vary significantly across the country, they are generally lower than expected," and that fifteen of the eighteen states examined would have premiums below $320 per month, which CBO projections imply would be national average premiums.[12]

4. Please submit additional information on why some insurers submitted bids to participate in the marketplace only to revise these bids and reduce their prices when other insurers' rates came in lower.

Answer: Some insurers lowered their proposed bids when they were finalized. In Washington, D.C., some issuers have reduced their rates by as much as 10 percent.[13] In Oregon, two plans requested to lower their rates by 15 percent or more.[14] I believe this can at least partially be attributed to the competitive nature of the Marketplace.

5. Please submit additional information on why nearly half of consumers will likely be able to pay $100 or less per person for coverage in 2014.

Answer: Under the Affordable Care Act, advanced payment of the premium tax credits will be available to help eligible individuals and families afford insurance coverage through the Health Insurance Marketplace beginning January 1, 2014, and states may expand Medicaid eligibility for low-income adults. There are currently 41.3 million eligible uninsured Americans.[15] According to a September 2013 report, in the 25 states projected to expand Medicaid, a total of 23.2 million people, or 56 percent of the 41.3 million eligible uninsured, may qualify for Medicaid, CHIP, or tax credits to purchase coverage for $100 or less per person per month. If all states expanded their Medicaid programs, 78 percent of the 41.3 million eligible uninsured, or 32.1 million people, would qualify for Medicaid, CHIP, or tax credits to purchase coverage for $100 or less.[16]

6. Please elaborate on the fact that eight and ten marketplace consumers are expected to qualify for subsidies to make health coverage more affordable.

Answer: CBO has projected that about eight in 10 Americans who obtain coverage through the Marketplaces will qualify for assistance to make their insurance more affordable, an estimated 20 million Americans by 2017.[17] A family's eligibility for these affordability programs depends on its family size, household income, and access to other types of health coverage.

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[11] ASPE Research Brief: Market Competition Works: Proposed Silver Premiums in the 2014 Individual and Small Group Markets Are Substantially Lower than Expected – see: http://aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/ib_premiums_update.pdf

[12] http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf

[13] http://hbx.dc.gov/release/dc-health-link-applauds-aetna-decision-cut-rates

[14] http://www.oregonlive.com/health/index.ssf/2013/05/two_oregon_insurers_reconsider.html

[15] This number, based on the 2011 American Community Survey (ACS), is the estimate of Americans who are citizens or legal residents under the age of 65 and therefore eligible for coverage either in the Marketplace or through Medicaid. Some of these were eligible for Medicaid or CHIP coverage prior to 2014 but were not enrolled.

[16] http://aspe.hhs.gov/health/reports/2013/Uninsured/ib_uninsured.cfm

[17] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf